

**Professional Satisfaction Among Canadian Physicians:  
A Retrospective Look at Survey Results**

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## **Introduction**

Stress, burnout and workload are important topics of concern with respect to physician health. Numerous reports have come to the fore looking at these different characteristics. The aim of this paper is to bring together some physician survey data by which to better understand physician health of the past, present and the outlook for the future. This paper focuses on the 2004 National Physician Survey (NPS) as a main data source, complemented by information from other surveys and reports regarding the health of physicians.<sup>1</sup>

Various facets of professional satisfaction will be considered in relation to a variety of different areas, primarily, demographic and practice characteristics. This paper considers satisfaction with: hospital relationships, relationship with non-physician health care workers, current professional life and balance between personal and professional commitments. Within the latter, topics such as workload and on-call can be better explored, followed by a consideration of a maximum hours scenario. This analysis will form a solid base upon which to identify trends, understand what factors in particular influence a physician's satisfaction and therefore better plan for the future.

## **Methodology**

While the 2004 NPS was the main source of data for much of the analysis in this paper, other surveys including the 1999 Physician Resource Questionnaire, the 2001 Physician Resource Questionnaire, and CMA Membership Baseline Questionnaires also were data sources. Respondents to the 2004 NPS ranked their satisfaction with various aspects of their professional lives on a 5-point scale. For the purpose of this paper, "satisfied" will include "somewhat satisfied" or "very satisfied" responses. "Dissatisfied" will include "somewhat dissatisfied" or "very dissatisfied" responses. For the purposes of this paper, "FPs" refers to both GPs and family medicine specialists.

## **Professional Satisfaction**

Table 1 shows that the vast majority of physicians (86%) were satisfied with their relationship with patients and at least three-quarters were satisfied with their relationship with other physician and non-physician providers. This figure dropped to just over half when reporting on their relationship with hospitals.

Table 1: Professional Satisfaction

Professional Satisfaction	n=21296	% satisfied	% dissatisfied
Relationship with patients		86%	1%
Relationship with FPs		76%	3%
Relationship with specialists		76%	6%
Relationship with non-physician health-care workers		75%	4%
Relationship with hospitals		51%	20%
Current professional life		69%	15%
Availability of CME/CPD		73%	9%
Balance between personal and professional commitments		54%	28%
Ability to find a locum		16%	31%

Source: 2004 National Physician Survey

With regard to their current professional life, physicians expressed a considerable degree of satisfaction (69%) however, only 54% indicated they were satisfied with their balance between personal and professional commitments. The ability to find locum tenens was the only area more likely to be rated as dissatisfactory (31%). Interestingly, 60% of family medicine resident respondents to the 2004 NPS Resident Questionnaire indicated that they planned to do locum tenens following completion of residency training. Over two-thirds (68%) of female family residents and 56% of male family residents indicated they intended to practice as a locum tenens after completion of residency perhaps indicating a future with greater facility in finding locum tenens.

Below is a more detailed analysis of each category of professional satisfaction

### **Satisfaction with Current Professional Life**

As with other aspects of professional satisfaction, males and females had similar contentment levels with their current professional life (both over 70% satisfied); similarly, there appears to be little difference between rural and urban physician populations in considering satisfaction with current professional life.

With respect to types of professional satisfaction examined in this report, the largest difference between FPs and specialists was with their satisfaction with their current professional life as 66% of FPs were satisfied and 73% of specialists reported the same. In comparing FPs and specialists who have the major responsibility for the care of children, the most apparent difference is seen with respect to satisfaction with current professional life as while 66% of FPs with the major responsibility for care of children cited satisfaction with their current professional life, 75% of specialists indicated the same level of satisfaction.

It is interesting to compare how Quebecois and Ontarian physicians felt about their current professional life as less than 10% of physicians practicing in Quebec claimed to be dissatisfied compared with double that number for those physicians practicing in Ontario. Satisfaction levels were high amongst those in Nova Scotia and Saskatchewan

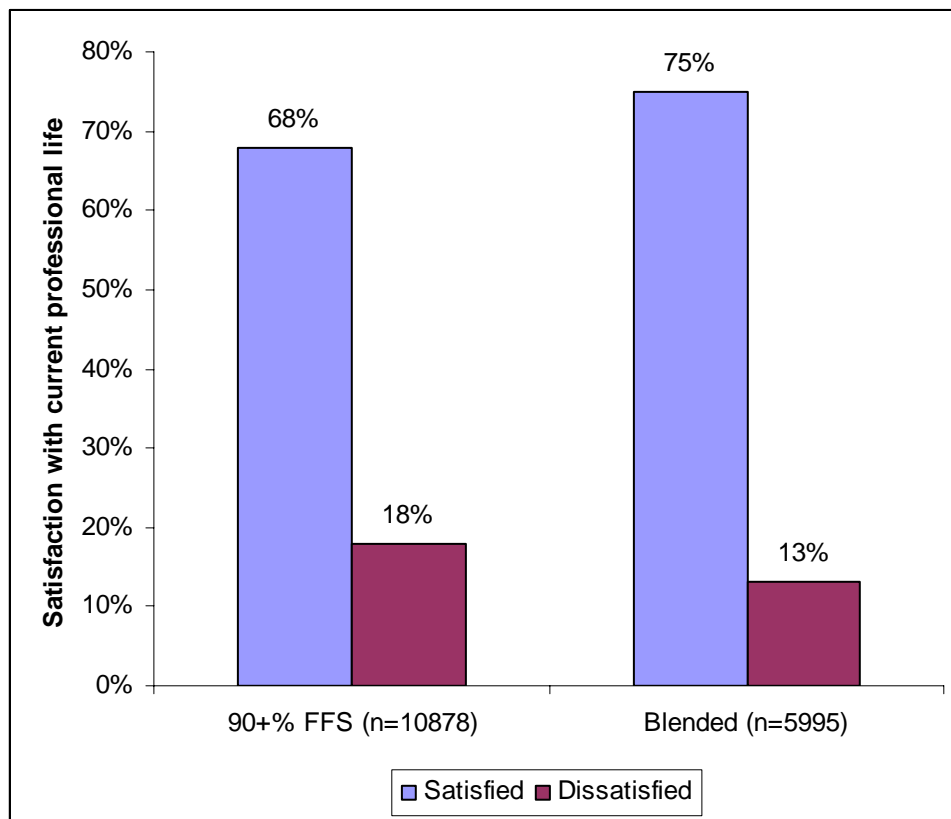
with 73% of both physician populations stating they were satisfied with their current professional life.

Physicians whose main patient care settings were academic health sciences centres (75%) and community hospitals (74%) were more likely to be satisfied with their current professional life than those providing patient care in private offices (63%).

Satisfaction did not appear to be dependent upon the way in which a practice is organized. No difference was found between physicians working in group or solo practice with respect to their satisfaction with their professional life.

Method of remuneration was compared to identify any differences that may exist regarding level of satisfaction with current professional life. A consideration of the two largest categories reveals that slightly more physicians who were paid by a blended form of remuneration (eg. ffs + salary) were more satisfied with their current professional life than those earning 90+% via the fee-for-service (ffs) method, as is depicted in Graph 1.

Graph 1: Satisfaction with Current Professional Life by Remuneration Mode



Source: National Physician Survey, 2004

### **Family Physician/Specialist Relationships**

Reported satisfaction with relationships between family physicians and specialists is interesting to consider.

Forty-one percent of FPs were satisfied in their relationship with fellow family physicians and 42% of specialists were satisfied with their relationship with fellow specialists. However, only 32% of specialists were satisfied with their relationship with FPs and only 23% of FPs were satisfied with their relationship with specialists (Table 2).

Table 2: Satisfaction with FPs and Specialists

Professional Satisfaction	FPs n=11041 % satisfied	Specialists n=10255 % satisfied
Relationship with family physicians	41%	32%
Relationship with specialists	23%	42%

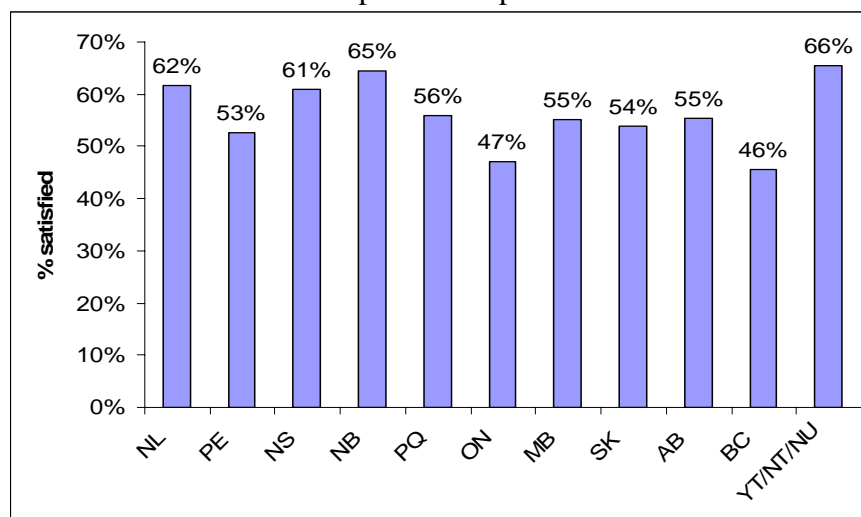
Source: 2004 National Physician Survey

### Relationship with Hospitals

Male and female physicians were almost equally satisfied with their relationship with hospitals; similarly, differences between FPs and specialists were negligible. Physicians in New Brunswick were among those most content with their relationships with hospitals, (65%). Ontarians and British Columbians, on the other hand, were among those least likely to express satisfaction with their relationship with hospitals with only 47% and 46% respectively indicating they were satisfied (Graph 2).

Overall, Atlantic physicians were more likely to state they were **very satisfied** with the various variables examined in this study than were the rest of the regions. In fact, 22% of Atlantic physicians say they were **very satisfied** with their relationship with hospitals.

Graph 2: Satisfaction with Relationship with Hospitals

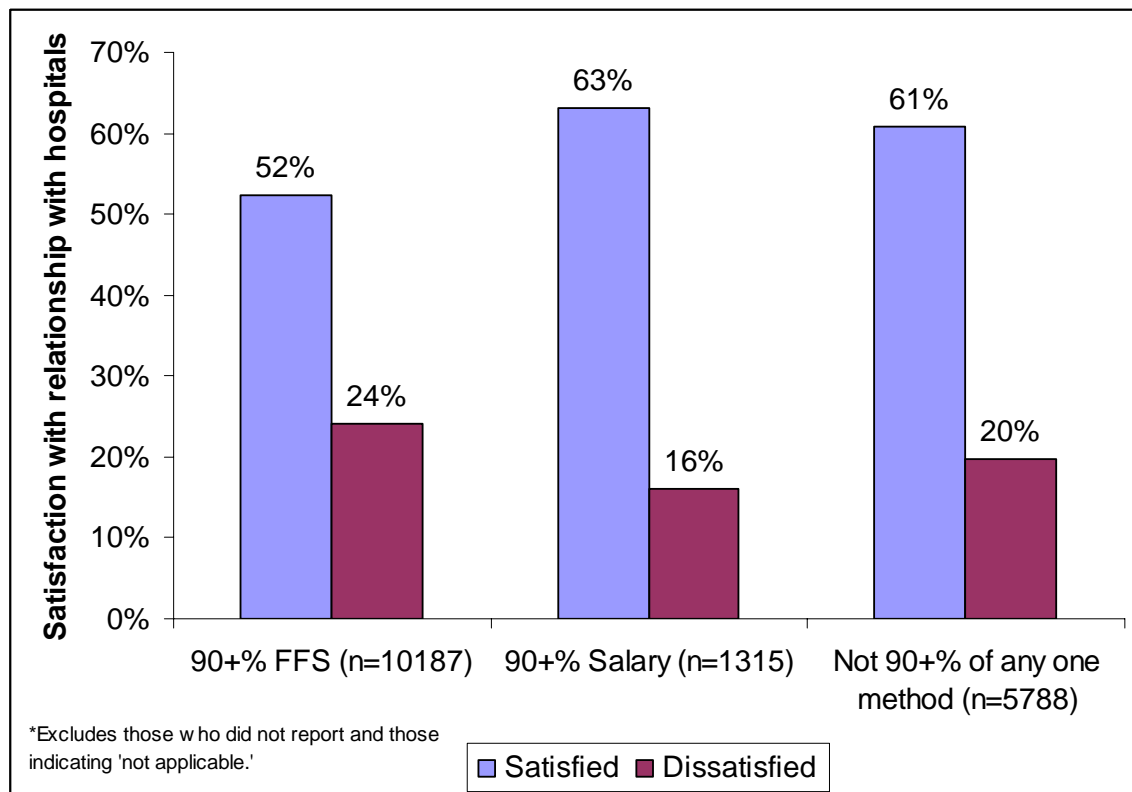


Source: National Physician Survey, 2004

A greater degree of satisfaction with hospitals was seen amongst those physicians whose primary population served is rural rather than urban (65% versus 51%).

Of those who indicate having some sort of relationship with hospitals, method of remuneration is interesting to consider in terms of corresponding levels of satisfaction with these relationships. Graph 3 illustrates that 52% of those receiving 90+% of their income via fee-for-service were satisfied with their relationship with hospitals, whereas over 60% of physicians receiving 90+% of their income via blended payment cited the same level of satisfaction.

Graph 3: Levels of Satisfaction for Those Reporting a Relationship with Hospitals by Type of Remuneration\*



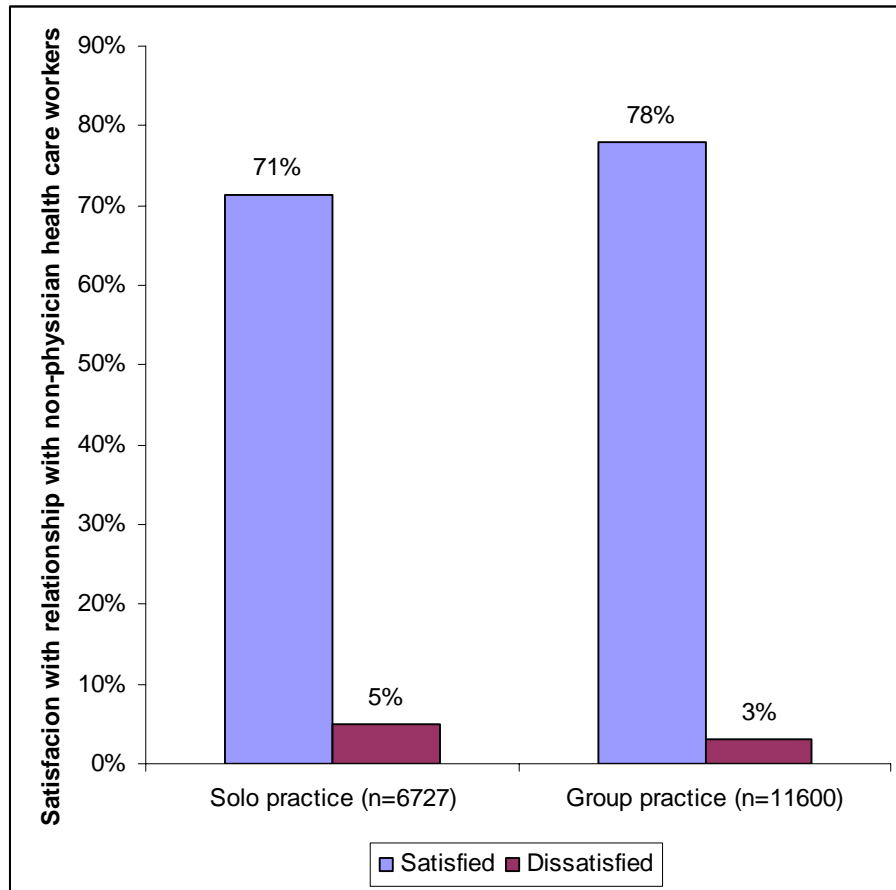
Source: National Physician Survey, 2004

### Satisfaction with Relationships with Non-physician Health Care Workers

Satisfaction with non-physicians was high among both male and female physicians and FPs and specialists (all at least 75% satisfied). There were however, a few differences noted across the provinces in terms of physician satisfaction with relationships with non-physician health care workers. There was a ten percentage point difference between Nova Scotians (82%) and Ontarians (71%) expressing satisfaction with their relationship with non-physician health care workers. In terms of region, nearly 40% of Atlantic physicians said they were **very satisfied** compared to only a quarter of Quebec physicians.

While 72% of those whose main patient care setting is a private office/clinic were satisfied with their relationship with non-physician health care workers, the percentages were a bit higher for physicians working in academic health sciences centres (80%) and community hospitals (79%). Also of note is that those in group practice were slightly more satisfied with their relationship with non-physician health care workers than were those in solo practices (Graph 4).

Graph 4: Relationship with Non-physicians by Practice Organization



Source: National Physician Survey, 2004

Differences were also seen between those serving primarily urban and those serving primarily rural populations with 75% of the former and 84% of the latter expressing satisfaction with their relationships with non-physician health care workers.

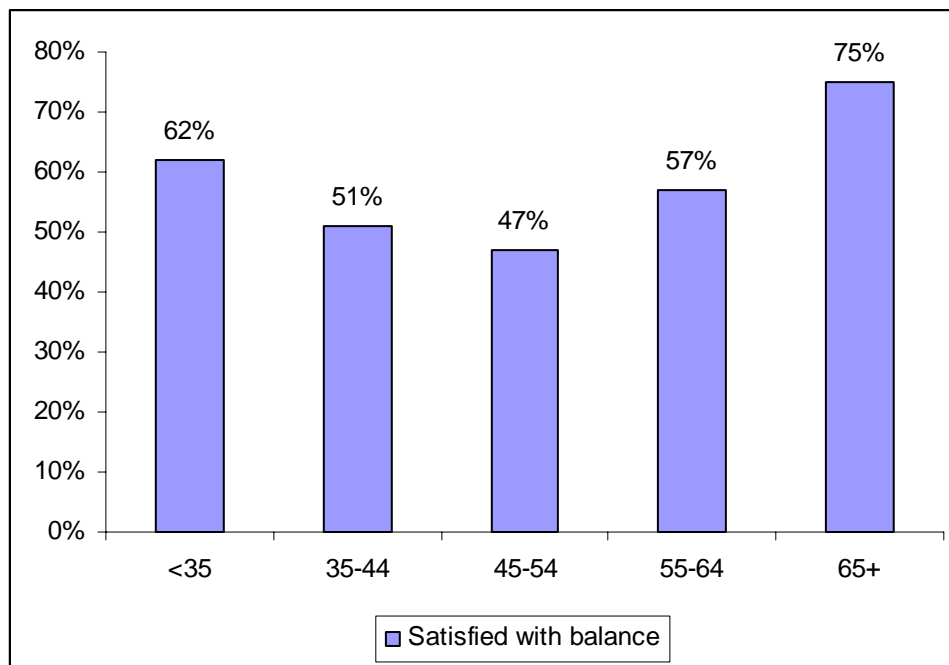
Those receiving a blended form of remuneration were more likely to be satisfied (83%) with their relationship with other health care workers than were those primarily paid fee-for-service (73%). Although a much smaller group, those paid sessional/per diem/hourly reported the most satisfaction at 84%.

## **Satisfaction with the Balance between Personal and Professional Commitments**

Nearly equal proportions of male and female physicians indicated they were satisfied with the balance between personal and professional commitments. Similarly, little difference existed between FPs (52%) and specialists (55%) who indicated they were satisfied with the balance achieved between personal and professional commitments. Little difference exists regarding satisfaction with balance between personal and professional commitments when physicians serving primarily urban populations are compared with those serving rural ones.

With respect to age, Graph 5 demonstrates that respondents in the youngest cohort (less than 35) and in the oldest cohort (65+) are more satisfied than those between the two age groups. A similar relationship is seen when considering satisfaction with current professional life by age group. Both the youngest group (77% satisfied) and the oldest group (82% satisfied) indicated higher levels of satisfaction than those aged 35 to 64.

Graph 5: Very/somewhat satisfied with balance between personal and professional commitments



Source: 2004 National Physician Survey

The survey findings also revealed that those who changed to a multidisciplinary model within the last two years were just as dissatisfied (31%) with their balance between personal and professional commitments as all respondents combined (27%). Equal proportions of those earning 90+% of their incomes from fee-for-service (54%) and those paid by a blended method (55%) were satisfied with the balance they achieved between personal and professional commitments.

It should be noted that compared to the other types of satisfaction about which the respondents were questioned, dissatisfaction with balance (28%) was second highest following the dissatisfaction with the ability to find locum tenens (seen in Table 1).

Satisfaction with balance between personal and professional commitments was higher in PEI, Nova Scotia, New Brunswick, Quebec and the Territories, (ranging from 57% in Nova Scotia to 60% across the Territories), than across Ontario, Manitoba, British Columbia and Newfoundland where satisfaction ranged from 51% to 53% (see Appendix A).

While half of physicians (51%) whose main patient care setting is an academic health sciences centre were satisfied with their balance between personal and professional commitments, nearly 60% of those in community clinics reported the same degree of satisfaction.

### *Workload*

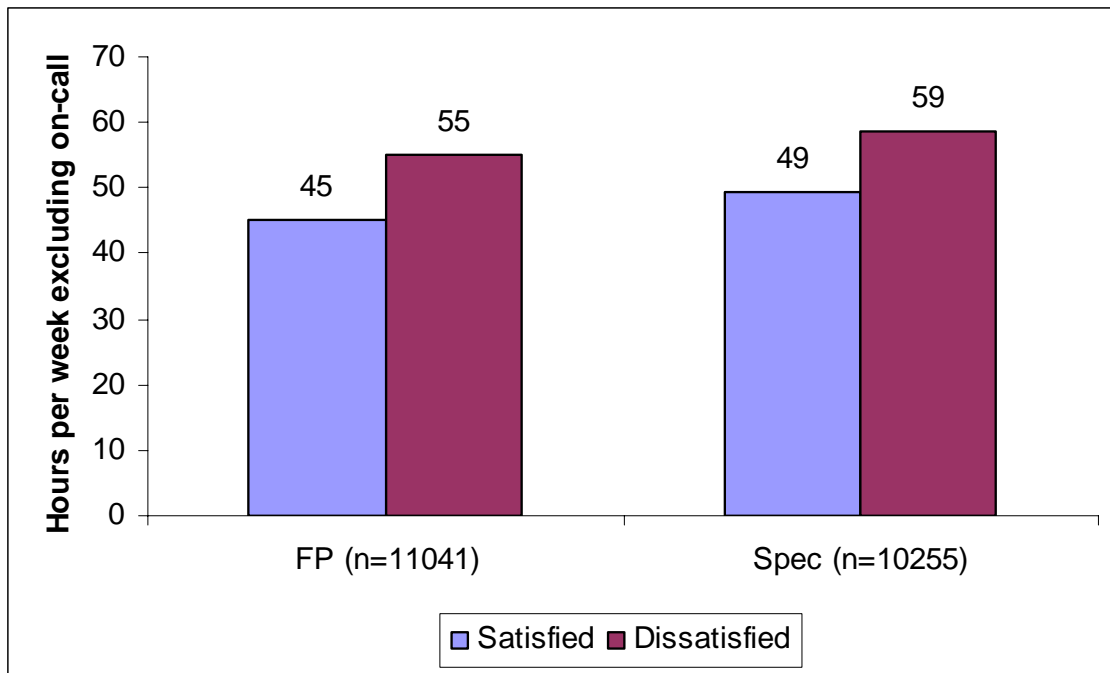
The workload of a physician appears to have a strong influence in determining satisfaction with balance between work and home life. As is seen in Graph 6, males reporting an imbalance averaged a greater number of hours than their female colleagues. Similarly, specialists averaged greater hours than FPs in the group that reported dissatisfaction with their balance (Graph 7).

Graph 6: Balance between Professional and Personal Commitments: by sex



Source: 2004 National Physician Survey

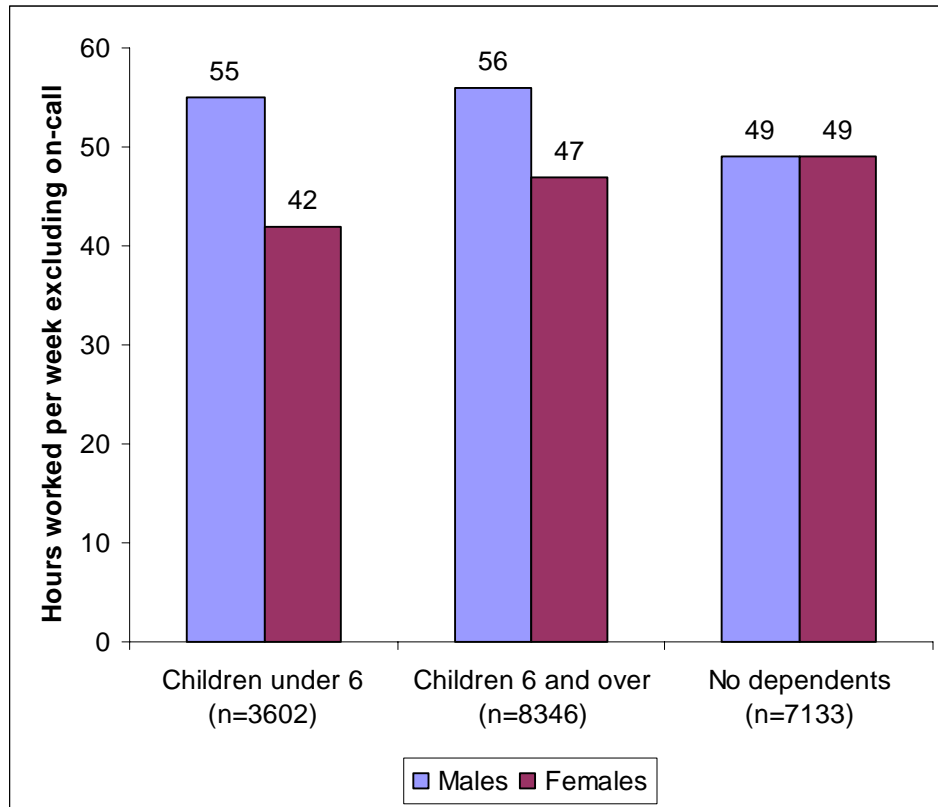
Graph 7: Balance between Professional and Personal Commitments: by FPs versus Specialists



Source: 2004 National Physician Survey

Discernible differences are apparent upon considering physicians with children by gender and hours worked per week (Graph 8). While males with children under six worked on average 55 hours a week, females with children of the same age category worked 42 hours a week. The difference narrows for physicians whose youngest is six and over; 56 hours are reported by males and 47 by females. The gap virtually disappears for physicians without dependents; males and females both average 49 work hours a week. Males with children or dependents tended to report more hours per week than males without children or dependents. The opposite is seen for female physicians.

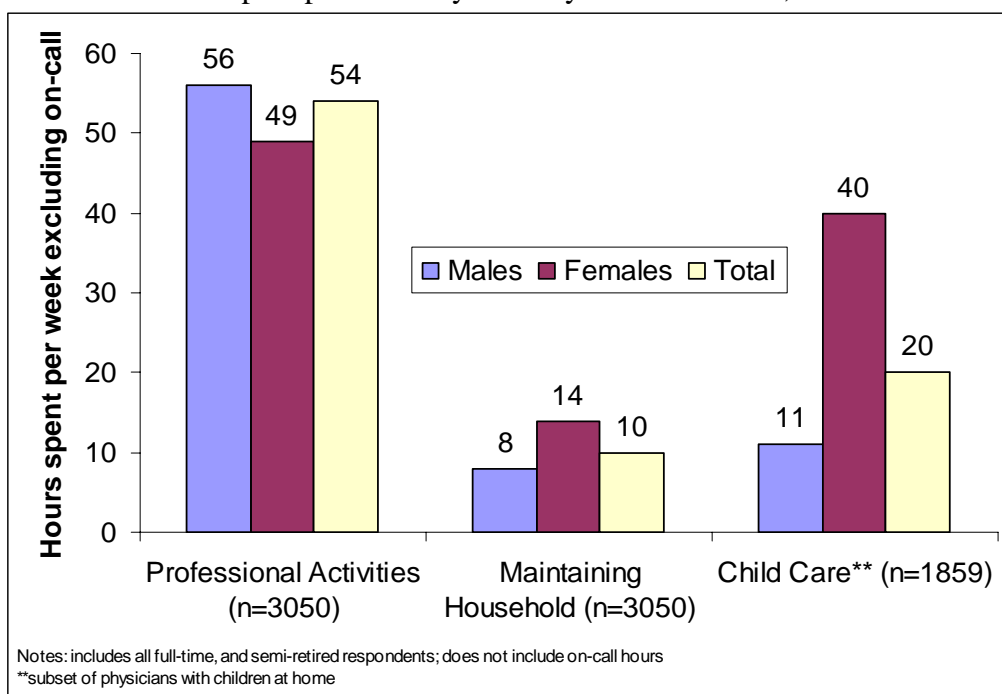
Graph 8: Hours Worked per Week by Type of Dependents



Source: 2004 National Physician Survey

It is also interesting to look at 1999 PRQ data for physicians with children at home to compare how males and females divide their work and home responsibilities (Graph 9).<sup>2</sup> While males spent 56 hours a week on professional activities with 11 hours on child care, female physicians spent 49 hours a week on professional activities and devoted 40 hours a week to child care.

Graph 9: Mean Hours Spent per Week by Activity & Sex: Canada, 1999



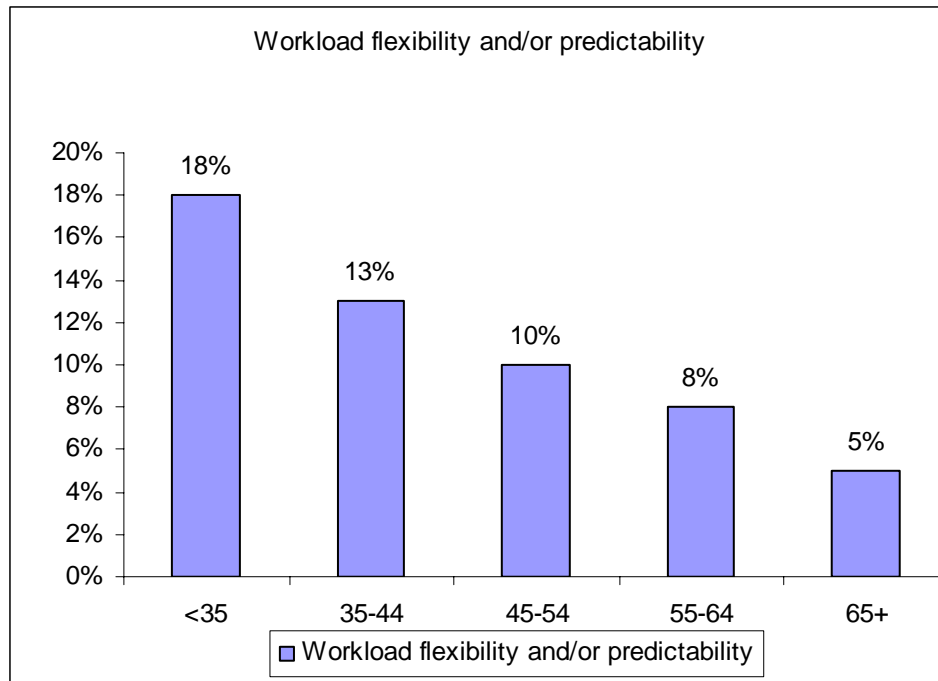
Source: 1999 CMA Physician Resource Questionnaire

With respect to burnout levels, in general, the more hours worked per week, excluding on-call, the more likely a physician is to be in advanced stages of burnout. While 44% of those working less than 40 hours/ week stated they were managing their stress levels, only 26% of those working 80 and more hours/ week had the same handle on their level of stress. Of importance, over half (53%) of those working 80 and more hours/ week considered themselves to be in advanced stages of burnout.<sup>3</sup>

As part of the 2001 PRQ, physicians were asked to indicate the extent to which they agreed with a variety of statements on professional stress.<sup>4</sup> It was most frequently agreed (strongly agree/agree) that it was difficult to get appropriate resources on behalf of patients (66%) and that their workload was heavier than they would like (65%). Clearly physician workload has been an issue over the years.

Flexibility in the workplace featured largely amongst younger cohorts of physicians when surveyed regarding the most important factor leading them to select medicine. In fact for those less than 35, 18% cited workload flexibility and/or predictability as the most important factor that led to current career choice (Graph 10). The older the physician, the less likely they were to cite this as their most important factor leading to current career choice (5% of those 65+ picked workload flexibility as their most important factor). For the youngest age group it is for the most part due to the fact that the group consists primarily of FPs who rate flexibility higher than specialists, especially in the younger cohorts.

Graph 10: Workload flexibility and/or predictability as the most important factor that led to career choice



Source: 2004 National Physician Survey

### *On-call hours*

On the 1999 PRQ, physicians were asked to rate a variety of aspects of their on-call responsibilities in terms of being a stress in their personal and professional life.<sup>5</sup> Most frequently cited as either stressful or very stressful were lifestyle restrictions at 57%. Of the on-call responsibilities they were questioned about, total on-call hours were rated very or somewhat stressful by 36% while frequency of on-site in ER was the least frequently cited as somewhat stressful or very stressful (21%).

Looking at on-call hours per month in relation to levels of satisfaction, a variety of telling relationships are noted. Total on-call hours a month do not seem to affect physician satisfaction with hospitals. The same is true with respect to their relationships with non-physician health care workers which seem to remain un-changed regardless of the number of hours spent on-call per month.

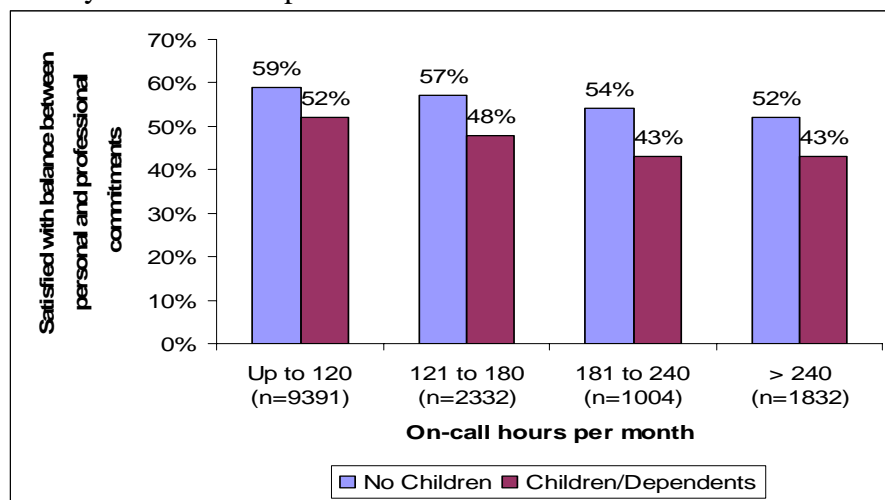
The ability to find locum tenens coverage seems to be more of an issue. While about one-third (32%) claimed finding locum tenens coverage was not applicable to them, for the remainder who answered, an interesting relationship was seen among those citing dissatisfaction with their ability to find tenens coverage. Of those who responded, while 48% of those who worked up to 120 hours/ month on-call cited dissatisfaction with finding locum tenens coverage, an even greater number (61%) of those doing more than 240 on-call hours/ month were also dissatisfied.

Interestingly, the total number of on-call hours a month does not seem to have a large effect on the satisfaction physicians have with their current professional life. Many (72%) of those who do up to 120 hours per month of on-call are satisfied with their current professional life and 68% of those who do over 240 on-call hours per month have the same level of satisfaction.

The greater the number of on-call hours worked, the more likely one was to cite dissatisfaction with balance between personal and professional commitments. This is an important relationship because fully 60% of physicians have dependent children. While 54% of those working up to 120 hours/ month were satisfied, 46% of those working more than 240 hours/ month also cited the same degree of satisfaction.

It is relevant at this stage to compare those who do not have children/ dependents with those who do when considering balance as it relates to total on-call hours/ month, (Graph 11). It appears the presence of children and working numerous on-call hours adds to the stress of balancing work and home commitments. Amongst those working more than 240 hours/ month over half of those without children were satisfied compared with 43% of those with children reporting the same level of on-call responsibility.

Graph 11: Percentage of those Satisfied with Balance between Professional and Personal Commitments by on-call hours per month and with/ without Children

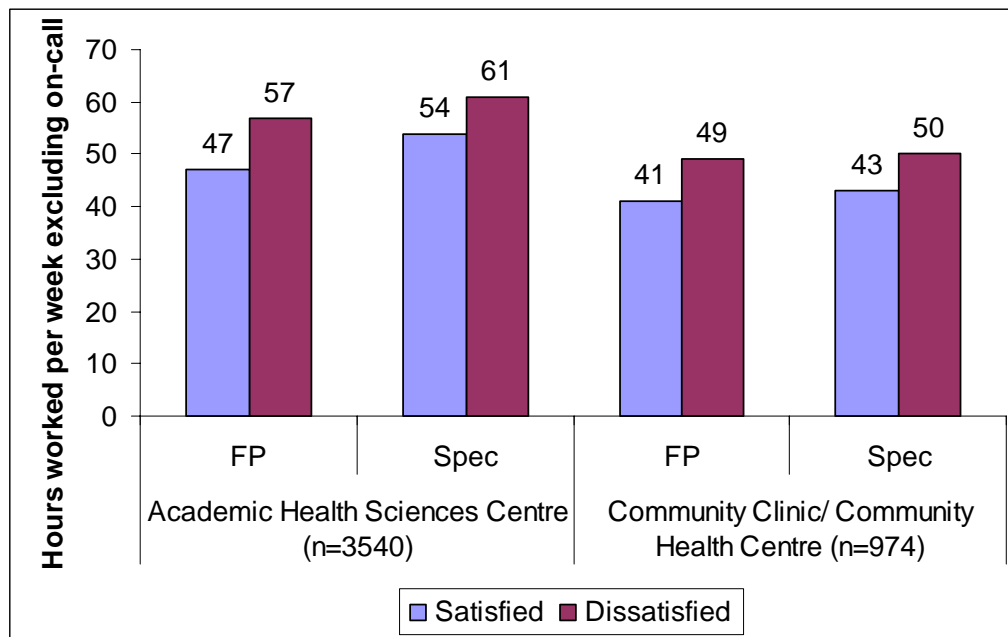


Source: 2004 National Physician Survey

### *Work/ Patient care setting*

Graph 12 shows that physicians providing their main patient care in community clinics/ community health centres worked fewer hours per week than those providing their main patient care in academic health sciences centres. Of note, those specialists working in community clinics/health centres who were dissatisfied with their balance between personal and professional commitments actually averaged fewer hours per week than the satisfied specialists in the academic health science centres.

Graph 12: Workload by Satisfaction with Balance between Personal and Professional Commitments: FP versus Specialists by Patient Care Setting



Source: National Physician Survey 2004

### **Maximum Hours Scenario**

Within a discussion of physician work hours, it seems relevant to consider the impact of physician work hours being restricted in the future. It is possible that European developments in the area of work hours regulation may one day impact on the North American landscape. Adopted in 1993, the European Working Time Directive (EWTD) has changed several times since its inception. It legislates maximum work hours to 48 hours a week and applies to all doctors except for those in training who typically work longer hours.<sup>6</sup> Slowly, however, the same legislated work hours are being phased in for these junior trainees.

The EWTD is not universally welcome amongst the physician workforce. It has been argued that having work patterns imposed upon the workforce may make matters even worse. One of the reasons the EWTD was put in place was to eradicate the threat of health and safety issues due to long work hours.<sup>7</sup> However, as at least one survey indicates, the disruption to the continuity of patient care brought on by such restrictions may prove extremely detrimental thereby outweighing the benefits. Not only will the patients feel the effects, but so too will junior trainees as well as physicians to varying degrees.

Many physicians in Canada work more than 60 hours a week excluding on-call duties. It is interesting to consider the impact on the total number of physician services provided if physicians either were restricted from working more than 60 hours a week or chose not to. In the 2004 NPS, physicians reported working, on average, 50.7 hours a week excluding time spent on-call. The average among those physicians whose workload did

not exceed 60 hours a week was 44.5 hours a week. If the physicians who work more than 60 hours a week are added in but a maximum workload of 60 is forced, the average rises to 48 hours a week. Table 3 demonstrates the effect of a maximum 60 hour work week on total services provided by NPS respondents.

Table 3: Effect of Establishing a 60 hour Maximum Work Week

<b>Survey Cohort</b>	<b>Avg h/week excluding on-call</b>	<b>Number of physicians reporting</b>	<b>Total work hours</b>
Original	50.7	20,332	1,030,832
Adjusted (max 60 hr work week)	48.0	20,332	975,936
Shortfall of hours provided by sample		1,030,832-975,936= 54,896 total h	
Estimated shortfall of physicians		54,896/48.0 = 1,144 physicians	
New number of physicians required		20,332+1144= 21,476 (5.6% increase)	
Estimated national number required		61,803+ 5.6% increase = 65,264	
Estimated shortfall for Canada		65,264-61,803 = <b>3,461 physicians</b>	

Source: 2004 National Physician Survey & the 2004 CMA Masterfiles

This analysis predicts a shortfall of 54,896 physician hours. In order to maintain an average of 48 hours a week per physician (excluding on-call), with no physician averaging more than 60 hours/week, 5.6% more physicians would be required in this scenario to provide the same number of work hours. Approximately 3,461 more physicians would be required in Canada. Using this same method it is found that a work week of no more than 50 hours per physician would result in a shortage of 8,900 physicians and a 14.4% increase to the current supply would be required.

### **Satisfaction with Ability to find Locums**

This analysis of professional satisfaction would not be complete without a more in-depth consideration of the low percentage citing satisfaction with their ability to find locums. As over 30% of respondents answered that the ability to find locums was not applicable to them, analysis with these respondents removed is necessary. Amongst this cohort which rated the ability to find locums, 25% cited it as satisfactory and 47% were dissatisfied. A gender analysis revealed that more females (54%) are dissatisfied than are males (48%). In the case of FPs versus specialists, 55% of FPs cited dissatisfaction with their ability to find locum tenens coverage while 36% of specialists did the same.

### **Stressful Areas of Practice**

When asked in a 2006 CMA membership survey whether or not physicians would recommend the profession to their son or daughter, 64% (an increase from 61% in 2004

and 52% in 2002) said they would and 31% said they would not (a decrease from 34% in 2004 and 41% in 2002). While these results apply only to CMA members, it may be an indication that physicians are seeing the career of medicine in a more positive light than they did a few years ago.

Demographically, those who would recommend the profession (as indicated in both the 2004 and 2006 membership surveys) are mostly medical students, younger than 35, French-speaking living in Quebec, specialists and Atlantic Canadians. The main reason cited for the recommendation is a satisfying, rewarding career. Those who would not recommend the profession are generally English speaking, GPs, sole practitioners, aged 45-54 and live in ON or BC. Their main reasons for *not* recommending the career include stress, the poor lifestyle associated with being a physician and the poor work environment. These provide a good base upon which to consider stressful and rewarding professional activities as cited by respondents to the 2004 NPS.

The most frequent cited area of stress was on-call responsibilities. This was mentioned close to 60% more often than the next most frequently cited issue. The second most reported item of stress was paperwork followed by difficulty accessing specialist care for patients.

Overall, stress that could be categorized as relating to a particular area of practice (on-call, emergency, night shifts, etc.) was mentioned by 31% of respondents. Rural doctors were more likely to record on-call duty and emergency work as stressful aspects of practice compared to their urban colleagues.

The proportion of respondents who find specific areas of practice stressful, varies across age groups. The younger the respondent, the more likely they were to cite specific areas of practice as stressful (46% of those younger than 35 as opposed to 24% of those 65 and older cited specific areas of practice as stressful). Upon a more detailed look it appears that on-call duties and emergency may account for the differences seen in age when it comes to stressors. These two factors were some of the most commonly cited stressful factors within the cohort of young physicians.

Administrative stress (paperwork, government, medico-legal, etc.) was cited by 21% of physicians and 19% reported the work environment (inadequate remuneration, limited resources, long hours, etc.) as being stressful.

Provincial differences are seen with regard to administration/business types of stress with just 10% of Quebec doctors citing this as stressful and 26% of Ontario doctors citing the same. When broken down it appears this difference was largely attributed to paperwork with just 2% of Quebec physicians citing paperwork as stressful and 12% of Ontario physicians reporting the same. There were also regional differences seen with regard to wait times. Topping the list of those who mentioned it as a stressor was BC (17%) compared with 7% of physicians in Quebec.

On the other side of the equation, the most frequent cited rewarding area was patient care and interaction. This was mentioned close to 3 times more often than the next most frequently cited rewarding items, teaching followed by patient satisfaction.

## **Future Practising Physicians**

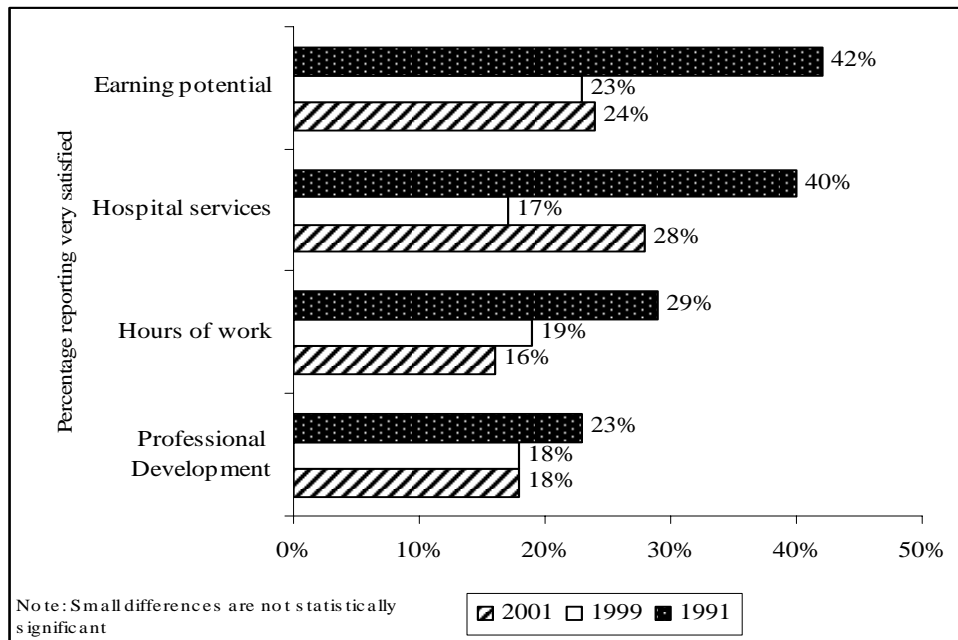
It is interesting to examine the deciding factors in selecting area of residency as revealed in the 2004 National Physician Survey of Residents. Most specialty residents (83%) cited intellectual stimulation/ challenge as a reason for their choice of area of residency compared with two-thirds of family medicine residents. Eighty-two percent of family medicine residents chose the doctor-patient relationship and 81% cited workload flexibility and or predictability as reasons for choosing their area of residency, while just 61% of specialists chose the former and 50% the latter. Other areas of difference are seen with regards to earning potential with 4% of family medicine residents citing earning potential as the reason to enter family medicine compared to nearly 30% of specialty residents citing the same. Ability to pursue non-work related interests was also relatively popular among family medicine residents (63%) while 39% of specialty residents cited this same reason.

According to the 2004 National Physician Resident Questionnaire, 30% of second year family medicine residents intended to primarily serve urban/suburban populations and 21% of the same residents intended to primarily serve a small town. Concurrently, 50% of second year specialty residents planned to primarily serve urban/suburban population and just 8% of specialty residents plan to serve a small town. These intentions are worth noting as NPS 2004 data shows greater likelihood of satisfaction with relationship with hospitals and non-physician health care workers amongst those serving primarily rural populations.

## **Rural Physician Studies**

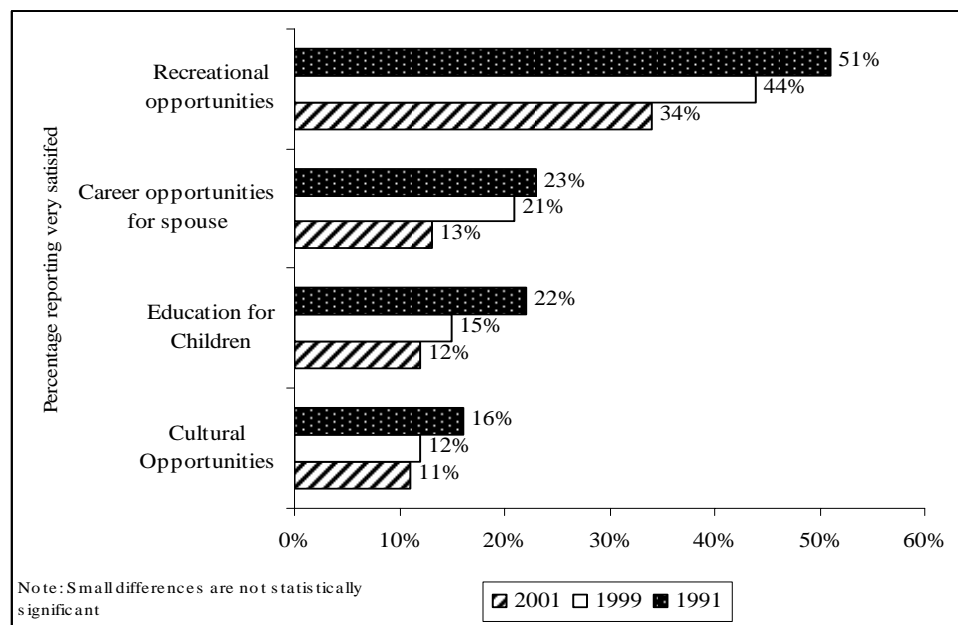
Selected findings on satisfaction with rural practice are available from the Survey on Rural Health Practice in Canada, 2001. Among professional factors, almost two-thirds (64%) of rural physician respondents were very or somewhat satisfied with the availability of hospital services while 58% indicated the same level of satisfaction with their earning potential.<sup>8</sup> Support from other physicians for coverage/ vacation relief was rated as very or somewhat satisfactory by over half of the respondents (56%) compared with just under half (47%) rating satisfaction with hours work similarly. Career advancement opportunities saw 28% of rural physicians indicate they were very or somewhat satisfied and another 28% indicate they were very or somewhat dissatisfied. In terms of personal factors, over three-quarter (76%) reported being very or somewhat satisfied with the sense of being appreciated by the community. Nearly equal proportions of respondents indicated they were very or somewhat satisfied with their sense of belonging to the community (70%) and with the recreational opportunities. Less than 40% of rural physicians were very or somewhat satisfied with educational opportunities for their children (39%) and job or career opportunities for their spouse (38%). A few of the personal and professional factors could be tracked from earlier surveys and for all of the comparable factors, there was a decrease in satisfaction between 1991 and 2001. As is shown in Graph 13, the percentage of physicians who were *very* satisfied with their earning potential in 1991 dropped significantly from 42% to 24% in 2001. Similarly, 40% of respondents were *very* satisfied with the availability of hospital services in 1991, compared to 28% in 2001.

Graph 13: Satisfaction with Rural Practice, Professional Factors



Source: The Development of a Multistakeholder Framework/Index of Rurality

Graph 14: Satisfaction with Rural Practice, Personal Factors



Source: The Development of a Multistakeholder Framework/Index of Rurality

The same trend was seen with personal factors (Graph 14). Fewer rural physicians were very satisfied with career opportunities for their spouse (13% versus 23%). Similarly, while 51% were very satisfied with recreational opportunities in 1991, 34% indicated the same level of satisfaction in 2001.

## **Limitations**

Prior to accepting the analysis at face value, consideration of the limitations of this research is necessary. There are four primary limitations. First, as with most physician surveys, it should be noted that the responses are self-reported. Physicians may choose not to answer certain questions and despite all efforts to use clear language, in the end, each question is subject to the individual interpretation.

Secondly, few surveys achieve an ideal response rate and in the case of the 2004 NPS, 36% of all physicians in Canada answered the questionnaire. While the respondents appear reflective of the physician population in terms of gender, age and FP-Specialist split, there is a noted under-representation of Quebec respondents. The question of bias can only be partially answered by looking at such demographics and it has been suggested that workload results may overstate hours worked by physicians. In fact, the results of a non-response survey conducted for the 2004 NPS indicate that hours worked reported on the main survey may have actually been an under-statement of the workload of Canadian physicians.

Thirdly, this research is in isolation of other professions. Therefore, it cannot be said that the results are unique to physicians. A physician health survey, planned for the fall of 2006, will be utilizing questions that have been asked of nurses so that comparisons between these two professions will be possible.

Lastly, it should be noted that the ability to do sub-national analyses is dependent on the size of the respondent group. In the case of the 2004 NPS, provincial, some sub-provincial and even city-based analysis is possible which would not be the case with other sample surveys mentioned in this report.

Despite these limitations it is believed that the analyses presented in this paper can be applied to the Canadian physician population as a whole.

## **Summary**

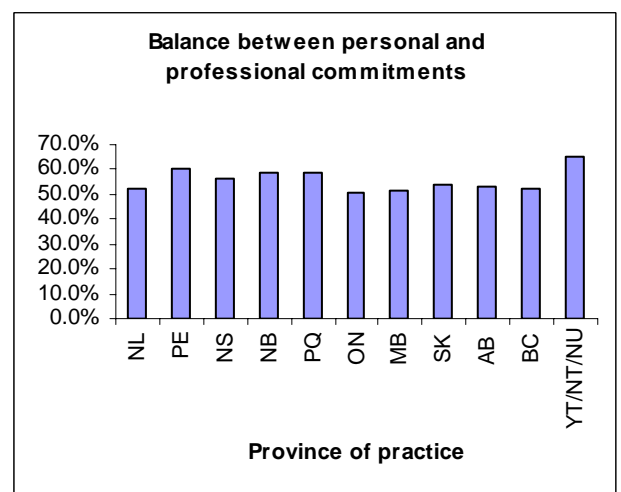
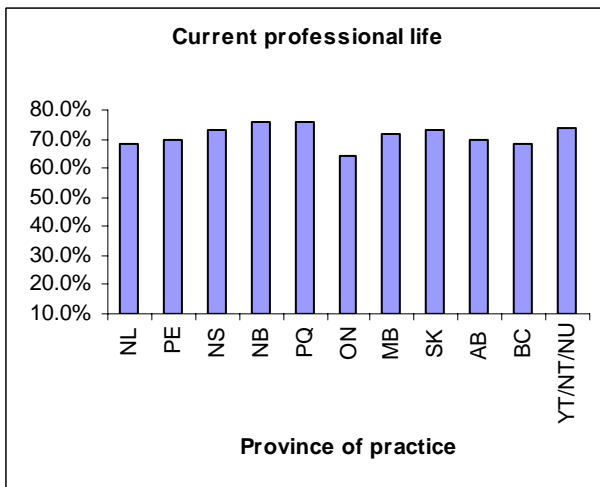
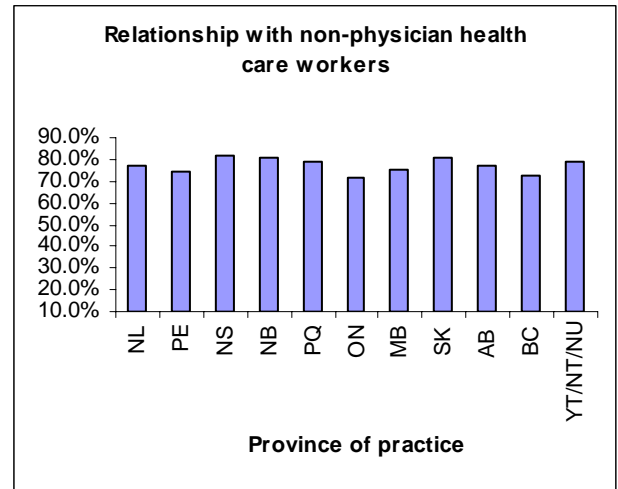
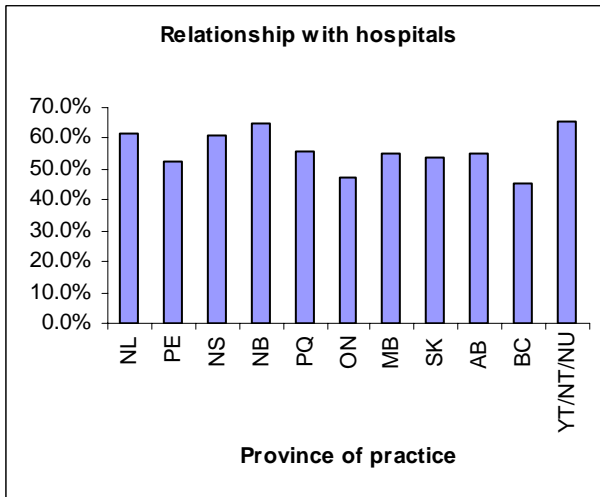
Through the culmination of research from a variety of reports and surveys dealing with the health of Canada's physician workforce, the state of the current landscape has been explored identifying areas of concern and suggesting possible strategies towards a future as rewarding as possible. Having considered satisfaction as a whole and how it pertains to physician demographics, work/patient care setting, remuneration, accessibility to services for patients, and on-call/hours per week, future scenarios can be approached in an informed manner. Equipped with the knowledge of the current satisfaction felt among physicians in Canada as a result of all aspects of their professional lives, the possibility of a maximum hours scenario was reflected upon as were the visions and anticipations of medical student residents entering the medical profession as our new physician workforce. The awareness of what factors in particular influence a physician's satisfaction as well as detract from it allow for better preparation for the future.

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**Appendix A:** Physicians Indicating Very or Somewhat Satisfied with Specific Factors



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- <sup>1</sup> National Physician Survey, Canada, 2004. Descriptive results available at: <http://www.cfpc.ca/nps/>. Accessed June 2006.
- <sup>2</sup> 1999 CMA Physician Resource Questionnaire Results. Descriptive results available at : <http://www.cmaj.ca/cgi/content/full/161/8/935/DC1>. Accessed August 2006.
- <sup>3</sup> CMA Study on Physician Burnout *CMA Centre for Physician Health and Well-being*, Nov 2003.
- <sup>4</sup> 2001 Physician Resource Questionnaire Results. Descriptive results available at: <http://www.cmaj.ca/cgi/content/full/165/5/626/DC1>. Accessed August 2006.
- <sup>5</sup> 1999 CMA Physician Resource Questionnaire Results. Descriptive results available at : <http://www.cmaj.ca/cgi/content/full/161/8/935/DC1>. Accessed August 2006.
- <sup>6</sup> MacDonald Rhona. How protective is the working time directive?, The aim of improving workers' safety and protection has got lost in the confusion. *BMJ* 2004; 329.
- <sup>7</sup> Cassidy C.J., Griffiths E., Smith A.F. 'Safety in sleep': anaesthetists, patients and the European Working Time Directive. *Anesthesia* 2004; 59
- <sup>8</sup> Adams, Owen, Lynda Buske, Louise Marcus, Tara S. Chauhan, Lisa Little, Lee Teperman, Janet Cooper, Kirsten Woodend. 2003. *The Development of a Multistakeholder Framework/Index of Rurality*. Ottawa: Canadian Medical Association.