Atlantic Provinces Medical Peer Review

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PHYSICIAN QUESTIONNAIRE

This questionnaire is designed to provide APMPR with the most current information about you and your practice. The information enclosed will be reviewed by the Committee and individuals appointed to discuss and/or review your practice, and by APMPR staff. Not all questions will apply to every physician If, for instance, your practice is hospital-based, questions about staffing and facilities may be beyond the scope of your knowledge, and area of responsibility. In any event, if you do not believe a specific question or series of questions is relevant to your practice, please indicate N/S (Not Applicable).

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ **SEX : M** ☐ **F** ☐

MEDICAL DEGREE FROM UNIVERSITY OF: _____ **YEAR:** _____

Year internship/residency program completed: _____

Total years of post-graduate training (internship/residency): _____

Hospital/Location(s) for Internship/Residency	Type of Training	Year

College of Family Physicians of Canada: **Certificant:**_____ **Member:** _____
Royal College of Physicians and Surgeons of Canada: _____**Fellowship:** _____
Year: _____ **Specialty:** _____

Hospitals with which you are affiliated:	Admitting Privileges
_____	**Yes** ☐ **No** ☐
_____	**Yes** ☐ **No** ☐

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PRIMARY PRACTICE ADDRESS: ***(location in which you see the majority of your patients)***

Hospital/Facility and address

_____

_____

_____

_____

Email address: _____

_____ _____ _____

Office telephone Cell/Home telephone Fax number

How many years have you practised in your current community? _____

SECONDARY PRACTICE OR MAILING ADDRESS (*if different from above)*

Hospital/Facility and address

_____

_____

_____

Office telephone _____

1. **<u>WHAT IS YOUR PRACTICE STATUS?</u>**
   If you are <u>not</u> currently involved in active practice, it is only necessary to complete the demographic information above, and this section #1.

   I provide surgical assistance only: Yes ☐ No ☐

   I am <u>fully retired</u> from all clinical practice (*do not treat or prescribe for patients*): Yes ☐ No ☐

   Date of retirement: _____

   I am on medical/maternity leave: Yes ☐ No ☐ Expected return: _____

   I intend to return to practice: Yes ☐ No ☐ Approximate date: _____

   ☐ ***By placing a check mark in the box, you verify that the information provided on this questionnaire is correct, true and accurate.***

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2. WHAT IS YOUR PRACTICE STRUCTURE?

Please indicate the number of full and part-time personnel with whom you work on a regular basis (daily/weekly) in your office practice.

For Office Practice	# F/T	# P/T
Physicians		
Registered Nurses/RNA's		
Nurse Practitioners		
Administrative Staff		
Other (please specify:		

Do you share with other physicians in your office practice?

Staff Yes _____ No _____
Office space Yes _____ No _____
Patient records Yes _____ No _____

Please describe your arrangements for the provision of patient care in your absence, i.e. cross-coverage, vacations, etc.

Please indicate your access to, or the availability of, the following (please enter Yor N)

basic laboratory services (i.e. hemoglobin, urine, blood glucose analyses, etc)	
advanced lab services (i.e. bone density, cardiac stress test, electromyography, etc)	
basic radiological services	
CT scans or MRI's	
specialists to which you can refer	
one or more long term care facilities in your community	
social service agencies to support your care of patients	
regular contact and interaction with peers	

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Please indicate at which location you see patients, the number of patients seen, and the number of hours spent in direct patient contact in a typical work week. Please do not provide a range, but indicate the upper limit of patients seen, and the number of hours you spend in direct patient contact.

Facility - please circle the one which best describes your primary area of practice	**# patients seen**	**# hrs direct patient contact**
A. OFFICE PRACTICE		
Private Office		
Community Health Centre		
Family Health Network		
Walk-in Clinic, After Hours, Urgent Care (non-static patient base, no appointments, episodic care		
Academic Family Practice Unit		
Locum		
B. HOSPITAL- Please indicate if this is an academic teaching hospital		
Inpatients		
Outpatients		
Emergency		
Surgical Assists		
Day Surgery		
Hospitalist		
C. LONG TERM CARE FACILITY (nursing home, etc)		
D. GOVERNMENT FACILITY (armed forces, prison)		
E. HOUSE CALL SERVICE		
F. OTHER (please specify)		

Have you chosen to focus or restrict your practice? Yes ☐ **No** ☐
If yes, please specify:

What percentage of your patients are referred by other physicians? _____%
Do you foresee any significant changes in your practice in the next two years? _____
If yes, please specify:

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Which best describe your patient records:
Electronic medical/clinical/patient records: Yes___No___ Software used: _____
Hand-written records: Yes _____ No _____
Hospital records only: Yes _____ No _____
Are your complete medical records located in your office? Yes _____ No _____
If no, please indicate where and how you obtain your patients' complete records:

_____

Do you share files with other physicians? Yes _____ No _____

Language of Patient Files: English:_____ French: _____ Both:_____

In a typical week, please estimate the percent of your patient visits that fall within each of the following categories. Please do not provide a range, but indicate the upper limit of visits in each category. Please note that the total should equal 100 percent.

% Patient Visits	Category
	NEW PRESENTATIONS/ACUTE CONDITION MANAGEMENT: New or known patients with new complaints or conditions requiring the formulation of a diagnosis in an office practice setting.
	MANAGEMENT OF PATIENTS WITH ONGOING/CHRONIC CONDITIONS: Patients with chronic conditions requiring long-term monitoring with or without the presence of co-morbidities.
	CONTINUITY OF CARE AND REFERRALS: Patients who you refer for treatment, surgical procedures, diagnostic procedures or otherwise, to the care of other physicians.
	HEALTH MAINTENANCE: Patient visits for well care and preventive health maintenance (e.g. annual check-ups, screening, well baby visits, etc.).
	PSYCHOSOCIAL CARE: Patients to whom you provide general counselling, psychotherapy sessions or referrals to various supportive social agencies in their community.
	NEW CONSULTATIONS/PRE-OPERATIVE MANAGEMENT: New or known patients presenting prior to surgical/medical procedures for pre-operative examinations, testing and treatments.
	OPERATIVE PATIENT MANAGEMENT AND PROCEDURES: Providing patients with intra-operative or procedural treatments.
	POST-OPERATIVE MANAGEMENT AND FOLLOW-UP: Patients to whom you provide post-operative or post-procedural care, which may include follow-up of patients with conditions that could require long-term care.
	EMERGENCY MEDICINE MANAGEMENT: Patients to whom you provide care in the emergency department.
	OTHER: (please specify) _____
100%	**TOTAL**

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Practice Descriptor Codes (for use with question following)

	ANESTHESIA		OBSTETRICS AND GYNAECOLOGY		SURGERY (CONTINUED)
101	Anesthesia	501	Gynaecologic Oncology	810	Ophthalmology
102	Chronic Pain Management without general/spinal anesthesia	502	Gynaecologic Reproductive Endocrinology & Fertility	811	Orthopaedic Surgery
	GENERAL/FAMILY PRACTICE	503	Gynaecologic Surgery and prenatal care	812	Otolaryngology
201	General/Family Practice with active/admitting hospital privileges	504	Office Gynaecology	813	Plastic Surgery
202	General/Family practice without hospital privileges	505	Obstetrical Practice limited to prenatal care	814	Surgical Practice without operative treatment
	MEDICINE	506	Obstetrics	815	Thoracic Surgery
301	Allergy	507	Urogynaecology	816	Urology
302	Cardiology	508	Sexual Counselling	817	Vascular surgery
303	Clinical Immunology		PAEDIATRICS	818	Transplant Surgery
304	Clinical Pharmacology	601	Neonatology	819	Endoscopy
305	Critical Care Medicine	602	Paediatrics		OTHER
306	Dermatology	603	Paediatric Cardiology	901	Acupuncture
307	Emergency Medicine	604	Paediatric Nephrology	902	Administrative Medicine
308	Endocrinology	605	Paediatric Neurology	903	Community Medicine (Public Health)
309	Gastroenterology	606	Paediatric Surgery	904	Palliative care
310	Genetics	607	Paediatric Allergy/Clinical Immunology	905	Psychotherapy
311	Geriatric Medicine/Nursing Homes	608	Paediatric Oncology	906	Sport Medicine
312	Haematology	609	Paediatric Orthopaedics	907	Clinical Fellow-without moonlighting
313	Infectious Diseases	610	Paediatric Gastroenterology	908	Clinical Fellow-with moonlighting
314	Internal Medicine	611	Paediatric Haematology	910	Child and Adolescent Psychiatry
315	Medical Oncology	612	Paediatric Haematology/Oncology	911	Substance Abuse
316	Nephrology	613	Paediatric Infectious Diseases	912	Aviation Medicine
317	Neurology	614	Paediatric Respiratory Medicine	913	Hyperbaric/Diving Medicine
318	Nuclear Medicine		RADIOLOGY	914	Sleep Medicine
319	Occupational Medicine	701	Diagnostic Imaging	915	Complementary Medicine
320	Physical Medicine and Rehabilitation	702	Therapeutic Radiology/Radiation Oncology	916	Long Term Care
321	Psychiatry	703	MRI	917	Urgent Care/Walk in Clinics
322	Respiratory Medicine	704	CT (computed tomography)	918	EEG
323	Rheumatology		SURGERY	919	EMG
	LABORATORY MEDICINE	801	Laser Surgery	920	Spirometry
401	Medical Biochemistry	802	Assistance at Surgery	921	House Calls
402	Medical Microbiology	803	Cardiovascular Surgery	922	Sclerotherapy
403	Pathology-Anatomic	804	Clinical Associates-Surgical	923	Hypnotherapy
404	Pathology-General	805	Colorectal Surgery	924	Teaching
405	Pathology-Haematological	806	Cosmetic Surgery	925	Research
406	Pathology-Neurological	807	General Surgery	926	Administration (in Medical schools, hospitals etc.
		808	General Surgical Oncology	927	Other Professional Activities i.e. College Activities
		809	Neurosurgery		

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<u>Clinical Activity:</u> using the descriptor codes on the previous page, please describe your clinical practice. The focus should be on what you actually do, rather than any certification(s) you hold. If you list more than one code, please estimate the percentage of time you spend in each area.

Code	0 - 10%	11 - 20%	21 - 40%	41 - 60%	61 - 80%	81 - 100%
Other-specify _____						

Please list 5 - 10 of the most common conditions/diseases/procedures that you see/do in your practice:

3. <u>WHAT IS YOUR COMMITMENT TO CONTINUING MEDICAL EDUCATION?</u>

Please provide information about the type of professional development activities you participated in over <u>the last 12 months</u>, and the amount of time spent at each activity.

Regardless of your certification or membership status with the CFPC or the RCPSC, do you voluntarily fulfil their professional development requirement?

Yes _____ No _____ Unsure _____

Please estimate how many <u>hours</u> you spent on the following formal CME in the last twelve months:

	<10	11-20	21-30	31-40	41-50	>50
RCPSC/CCFP accredited courses, conferences, workshops						
Internet-based CME Activities (on-line journals, guideline						
Practice-based small group learning sessions						
Self-directed learning programs						
Hospital committees						
Hospital educational rounds						
Other courses, conferences & workshops						
Other: please describe						

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STAFFING

Please indicate the number of full-time and part-time personnel that you work with on a regular basis (daily/weekly) within your practice. For part-time laboratory physicians, please estimate the fraction of full-time work (e.g., 0.5 or half-time). For technologists, assistants, administrative staff, an estimate of total full-time equivalents is sufficient.

	# FT	#PT
Staff		
Laboratory Physicians		
Technologists		
Assistants		
Administrative Staff		
Other please specify_____		

Hours of Operation: _____

Number of Tests _____

Variety of Tests (e.g., bacteriology, biochemistry, haematology, blood bank, etc.; may be reported as DBS units) available:

EQUIPMENT

1. Microscope
   a. Make/Model/Year:
   b. Does the range of objectives suit the practice? Yes ☐ No ☐
   c. **IF NOT**, what are the deficiencies?
   d. Does it function properly? Yes ☐ No ☐
   e. Is it adjustable for Kohler illumination? Yes ☐ No ☐
   f. Is it cleaned, adjusted and maintained at least annually by a microscope technician? Yes ☐ No ☐
2. Miscellaneous
   a. Is there a bone saw and a containment system for surgical pathology specimens? Yes ☐ No ☐
   b. Is there an adequately ventilated and lighted surgical gross dissection bench? Yes ☐ No ☐
   c. Is the cryostat in reliably functional order and regularly maintained? Yes ☐ No ☐
   d. Is the dictation system for Gross, Frozen Section Gross and Microscopic descriptions reliable and convenient? Yes ☐ No ☐

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3. Level of Automation
   a. Which procedures are manual?

   _____

   b. Which procedures use automatic staining?

   _____

   c. Which procedures use an immunostainer?

   _____

PROCESSING

Please indicate the average processing times (i.e., the time between receipt of the specimen in the laboratory and availability of slides to the pathologists) of the following:

Case	Average Processing Time
Tissue	
Cytology	
Haematology	
Bone Marrow	
Special stain requests, including immunostains	
Gross descriptions typing time	
Microscopic and final report typing time	
Retrieval of stored reports, slides and blocks, when required for current case reporting	

STAIN AVAILABILITY

Please provide a list of stains used

Stain	Stain	Stain

On the next page of this questionnaire, we would like you to take a few minutes to reflect on your practice over the past twelve months, considering your areas of strength and areas which could be deficient. Please tell us what you hope to get out of this assessment, and state one specific question and/or learning objective for the review. (Your objective may be in a clinical area, relationships with patients, new CME you would like to explore, etc.)

Thank you for your participation in peer review.

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Reflecting on my current practice and patient management, I see my area(s) of strength as:

I believe that I may have certain deficiencies in:

I would like to have more clinical knowledge about:

Following this peer assessment, I would like to:

In the coming year, I hope to do CME in these specific areas:

In five years, I would like my practice to be

☐ **My Electronic Signature***

Date _____

**** By placing a check mark in the "My Electronic Signature", you verify that the information provided on this questionnaire is correct, true and accurate.***

CLEAR

***This will erase all data - save before clearing.**

PRINT **SAVE**