HQCA
Health Quality Council of Alberta

ROLE AND PROCESS OF PHYSICIAN ADVOCACY – A SURVEY OF ALBERTA PHYSICIANS

August 2015

Promoting and improving patient safety and health service quality across Alberta

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INTRODUCTION

CONTEXT OF SURVEY

In March of 2011, former Alberta Health[i] Minister Gene Zwozdesky requested an independent review of the role and process of physician advocacy. At that time, numerous physicians came forward to the Health Quality Council of Alberta (HQCA), under the protection of a quality assurance committee, to share their experiences with physician advocacy. Many of these stories were concerning. These shared experiences suggested at a minimum, that the roles and processes for physician advocacy were poorly defined; and at the worst, that physicians were sometimes ignored, intimidated, censored, or even punished for choosing to advocate for their patients. These allegations were particularly concerning, in light of the emerging scope and importance of physician advocacy responsibilities as defined by the Royal College of Physicians and Surgeons in their CanMEDS 2005 Physicians Competency Framework which states that: "as health advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations."

In view of these issues, it was important to systematically assess the experience of Alberta physicians concerning advocacy. Based on initial interviews and the very limited literature published on this subject,[ii] the HQCA developed a survey to assess: a) the extent to which the advocacy role of Alberta physicians is supported or obstructed; b) factors which contribute to this; and c) how Alberta physicians see their training and experience in advocacy. Content of the survey was informed by in depth interviews conducted by the HQCA quality assurance committee.[1]

In response to the recommendations from the HQCA's 2011 report,[1] a number of actions were taken across the province to address the issue of physician advocacy and intimidation. To assess whether perceptions of physician advocacy have changed, potentially in response to these actions, Alberta Health Services (AHS) requested that the HQCA repeat the survey in 2014. The survey was revised to accommodate common answers or themes from open ended questions provided in the 2011 survey. The complete 2014 survey can be found in Appendix I. The following report provides the results of the HQCA's 2014 *Role and Process of Physician Advocacy* survey, and compares 2011 and 2014 survey results to assess whether and how perceptions of physician advocacy have changed over time.

[i] Formerly, Alberta Health and Wellness (2011 survey administration).

[ii] A literature review was conducted for the HQCA by the Ward of the 21st Century. Although this review found very little published literature on physician advocacy, it provided some useful suggestions regarding the development of the *Role and Process of Physician Advocacy* survey content and structure used by the HQCA.

SURVEY METHODOLOGY

The HQCA's *Role and Process of Physician Advocacy* survey was designed to collect the opinions and experiences of physicians from all areas of medicine in the province, including emergency medicine, general internal medicine, pediatrics, general and orthopedic surgery, anesthesia, mental health, family physicians, and other specialists. To be inclusive of all of the different organizational, administrative, and clinical structures that exist across medical disciplines, the questions and their associated response options were also broad. For example, we ask about organizational leadership and department or division administration. We acknowledge that these terms may represent different aspects of the medical system and structure to different physicians. The HQCA's *Role and Process of Physician Advocacy* survey provides a broad persepective on the current opinions and experiences with physician advocacy in the province.

A public mail contact list for all registered physicians was generated by the College of Physicians and Surgeons of Alberta (CPSA). Because of privacy issues, private mail and email addresses were not provided. Given the expectation that this public contact list would not reach all potential respondents; that physician survey response rates are generally low; and that some breakdown by physician type and location was required; the HQCA chose to use a census rather than a sampling approach. This methodology was consistent with the 2011 *Role and Process of Physician Advocacy* sampling methodology.

A modified Dillman mail survey protocol was used with an initial mailing of the survey and supporting material, a reminder postcard, and a repeat mailing of the full survey package. The protocol was modified so physicians were able to complete their individual survey via a secure web address and log-in, if they chose to do so.

Overall, 9,167 survey packages were mailed, 516 were returned as invalid addresses and eight were declined. In total, 1,754 physicians completed the survey, either by mail (n = 1,316) or online (n = 438).[iii] This yielded an overall completion rate of 19.1 per cent.[iv] Estimates based on the 2014 *Role and Process of Physician Advocacy* survey results are considered accurate within ± 2.2 per cent, 19 times out of 20. Returned paper surveys were scanned and validated using *Teleform*, and web forms were filled and submitted directly, by physicians, online.

Quantitative Analysis

Data were cleaned and merged into an SPSS data file. Multiple mention, "choose all that apply", items were formatted as multiple response sets. Univariate, bivariate, and multivariate analysis was undertaken in SPSS software. Differences between the 2011 and 2014 groups were examined and significant differences

[iii] A few physicians completed the survey more than once, either by completing the survey online and by paper, or completing both copies of the paper survey that PRA sent to them. Duplicate surveys were removed based on the date of completion: the first survey to be returned to PRA by mail or completed online was kept for each physician who completed the survey more than once.

[iv] Response rate and margin of error for the 2014 *Role and Process of Physician Advocacy* survey is consistent with other Canadian surveys of physicians. For example, in 2012, 2013, and 2014, the National Physician Survey Canada-wide response rates were 24.0%, 17.5%, and 16.0%, respectively. For these surveys, results were considered accurate within ±2.2-2.4% and ±1.0%, and ±1.0%, respectively. Similarly, in 2013 and 2014, the National Physician Survey Alberta response rates were 20.8% and 16.9%, respectively and results were considered accurate within ±3.8 and ±3.7, respectively (http://nationalphysiciansurvey.ca/surveys/).

were identified for those cases in which 95 per cent confidence intervals did not overlap.[v] In this report we use the term ***significant*** to refer only to those findings that are statistically significant as determined by statistical tests (i.e. confidence intervals, p-values and/or z-values) with a probability value of less than or equal to 0.05 ($p \leq 0.05$).

Qualitative Analysis

A thematic analysis using qualitative research methods was used to systematically analyze comments from respondents. All data were de-identified prior to analysis and all comments anonymized to protect the identity of survey respondents.

The qualitative research analysis program NVivo[2] was used to organize comments into broad topics or themes. Six major themes were identified. In addition, a manual approach was used where each comment was reviewed independently and the comment, or a portion of the comment, was applied to the appropriate theme or sub-theme using topic coding. As a result of the manual review, one additional code was added by the analyst[iii]– Patient Care. The seven resulting themes were:

- Bureaucracy
- Advocacy
- Intimidation
- Resource scarcity
- Patient care
- Training and education
- Professional relationships

REPORT STRUCTURE

The body of this report is made up of the following sections:

1) Physician perspective on their advocacy role and formal training
2) Factors contributing to advocacy
3) Advocacy: Obstruction or support
4) Bivariate results – Physician specialty
5) Regression analyses
6) Qualitative analysis
7) Limitations
8) Conclusions

[v] *StatNews#73: Overlapping Confidence Intervals and Statistical Significance*. https://www.cscu.cornell.edu/news/statnews/stnews73.pdf

Summary

Physicians' comments show that there are many issues and concerns regarding physician advocacy in Alberta. Challenges and barriers to physician advocacy revolve mainly around AHS administration, at the manager level as well as the level of leadership for the organization, and a scarcity of resources within the healthcare system.

The system within which physicians must advocate for their patients was described as a "monolithic bureaucracy". Physicians commented that communication lines are vague and confusing, and the administration hierarchy is cumbersome, obstructive, and unqualified to make decisions which influence patient care. Physicians' comments further reflect the negative impact of working within AHS as it has undergone restructuring and its' perceived ongoing bureaucracy within the healthcare system.

Lack of support from professional bodies representing physicians was identified as an issue by some physicians, and the scarcity of resources emerged as a key theme affecting patient safety and the quality of patient care. Training and education for physicians in patient advocacy was also identified and it was recommended this training and education be extended to administrators and leaders within the health system to facilitate a better understanding of advocacy as a concept and how best to support physicians and patients.

Overall, physician attitudes, solutions, and practices towards patient advocacy revealed a sense of frustration and disillusionment within Alberta's current healthcare system. This frustration was tempered by comments that suggested physicians' desire change in a system perceived as unsupportive and dismissive of patient advocacy. Physicians' comments revealed a culture in which trust is lacking. This included trust between employees and co-workers, employees and supervisors, and especially between employees and the organization itself, represented by leadership.

7. LIMITATIONS

This survey and subsequent analyses have a number of limitations which should be considered. On the basis of the literature review, very little work has been published on the topic of physician advocacy and related issues. This work should be considered as an initial step in examining the role and process of physician advocacy in Alberta and possibly elsewhere.

7.1 Definition of Advocacy

The definition of physician advocacy as provided by the Royal College of Physicians & Surgeons of Canada in their CanMEDS 2005 Competency Framework was non-specific. To address this potential limitation, each physician participant was instructed to define advocacy for themselves based on this definition. This method provides the highest level of standardization possible given the limitations in the definition of physician advocacy; the ambiguity (and therefore the inherent error) is standardized across participants.

7.2 Survey Questions

The survey development process was guided by the literature review, the expert advisory panel, initial qualitative interviews (as part of a quality assurance process), and advice from the HQCA's survey and analytical team. It was developed within aggressive timelines, and preceded the wealth of qualitative information that was gathered in the full course of interviews. Optimally the findings of these qualitative interviews would have had a greater role in shaping the content and focus of the survey. More extensive pilot testing, or even cognitive and psychometric testing, could also have been conducted; however, this often takes years rather than months.

Several respondents expressed concerns regarding the survey and its focus. These included the need for a clearer definition of advocacy beyond the CANmeds description. Some terminology was perceived to be too general for consistent interpretation and a focus on only the past year for many questions was thought by some to be too limited. Given the complex interpretation and experience of the advocacy role, and lack of a detailed prior definition, an in-depth qualitative study in advance of a quantitative survey would have been preferred. Consequently, it is possible that important issues may have been overlooked or inadequately represented in the survey. Despite this, there is considerable convergence of the survey findings and the qualitative interviews which were conducted concurrently.

To be inclusive of all of the different organizational, administrative, and clinical structures that exist across medical disciplines, the questions and their associated response options were also broad. For example, we ask about organizational leadership and department or division administration. We acknowledge that these terms may represent different aspects of the medical system and structure to different physicians. The HQCA's *Role and Process of Physician Advocacy* survey provides a broad persepective on the current opinions and experiences with physician advocacy in the province.[xi]

[xi] The HQCA's *Role and Process of Physician Advocacy* survey was designed to collect the opinions and experiences of physicians from all areas of medicine in the province, including emergency medicine, general internal medicine, pediatrics, general and orthopedic surgey, anesthesia, mental health, family physicians, and other specialists.

Some new questions and response options were added to the 2014 version of the *Role and Process of Physician Advocacy* survey and changes in the coding and analyses were required to allow comparisons between 2011 and 2014 data. The numbers reported in this report may be different from those reported in 2011.

7.3 Survey Sample

The survey sample is potentially limited by response rate and possibly by selection bias. A raw response rate of 19.1 per cent for physicians is very respectable for surveys of physicians in general; however, this response rate is not sufficient to generalize to the entire population of Alberta physicians. While all Alberta physicians were theoretically given the opportunity to respond, the representativeness of the resulting sample is not proven and self-selection bias may be a concern if the experience of responding physicians is different than the 80.9 per cent who did not, or could not, respond.

In some cases, a respondent may have participated in the 2014 and the 2011 survey cycles. While this does not affect the reliability of the result for each individual survey year, caution must be employed in interpreting significant differences between survey cycles. In particular, statistical tests require an assumption that each respondent's result is present only in 2014 or 2011 but not both (independence assumption). To mitigate this, non-overlapping 95 per cent confidence intervals were used to determine statistical significance (alpha = 0.05). This approach to significance testing is more conservative than other statistical testing (e.g., independent samples t-tests); and may fail to identify significant differences when they exist, but when a significant difference between groups is found, there is a higher degree of confidence that this difference truly exists. [xii] This decision was based on the nature of the survey and results, and that this method is consistent with the analytical approach used in the original 2011 report.

7.4 Discrimination between different contexts for advocacy challenges

The quantitative survey results do not adequately discriminate between issues that have always made advocacy for individual patients challenging; issues that are organizational in nature; or issues related to healthcare services becoming more structured and process driven over time. It is difficult to draw conclusions with respect to these more singular aspects of advocacy. This survey has captured a broader view of advocacy, but the responses are variable with respect to which context of advocacy is being considered. Future research is required and should parse out these different contexts. Note: this limitation applies less to the qualitative analysis of open responses and final comments.

7.5 Qualitative Responses to open ended questions

While the qualitative responses to the final open-ended question and other open categories provide rich content, they are limited by the focused scope of the question. In addition, qualitative research is an exploratory process which involves deconstructing the dialogue and discourse of research participants. For this particular project comments from a survey were explored for emerging commonalities from the perceptions, perspectives, and opinions of respondents. These commonalities were presented in the

[xii] *StatNews#73: Overlapping Confidence Intervals and Statistical Significance*. https://www.cscu.cornell.edu/news/statnews/stnews73.pdf

form of themes to enhance understandings of the subject. By its very nature, qualitative research typically involves a low sample size and is therefore not generalizable.

Data are subjective in nature and analysis and interpretation of the data is subject to that of the analyst who is considered inclusive into the study itself. The qualitative analyst, through his/her analysis and interpretation of the data from the survey thus brings meaning to the words and phrases from the survey and communicates the interpretation within this report.[3]

Limitations identified for this particular project include restricted responses due to space limitations on the survey, inhibited desire to complete the open-ended question after time taken to answer the previous 32 questions, and no opportunity to clarify the intent of respondents due to the need to maintain anonymity of survey respondents. The credibility of respondents was not established based on this latter limitation.

8. CONCLUSIONS

The analysis and interpretation of questions and comments from the 2014 survey and the subsequent comparison to findings from the 2011 survey provides evidence that the many issues and concerns expressed in 2011 remained in 2014. Challenges and barriers to physician advocacy for patients revolve mainly around AHS administration, at the manager level as well as the level of leadership for the organization, and the scarcity of resources.

Since the HQCA's 2011 *Role and Process of Physician Advocacy* survey administration, some changes in physician responses have been noted. In 2014, a significantly greater percentage of physicians reported that their ability to effectively advocate was restricted by AHS. However, a significantly greater percentage of physicians also indicated that their ability to advocate effectively was enhanced by their own experience in advocating for their patients, and by a clearer understanding of the physician advocacy role where they work. In addition, as compared to 2011, in 2014 a significantly smaller percentage of physicians reported that their role as an advocate for patients *never* had a positive outcome for them as a physician and a greater percentage of physicians felt somewhat supported in their efforts to advocate for their patients over the past year. Finally, as compared to 2011, in 2014 a significantly greater percentage of physicians reported that their ability to effectively advocate was restricted by unsupportive or unresponsive organizational policies, structure, or culture. However, significantly fewer physicians reported that their ability to effectively advocate was restricted by unclear processes for advocacy.

In an environment where budgets are perceived to take priority over patient care, many respondents said the health system is under-resourced, resulting in sub-standard patient care. The administration (as defined by the physicians, who work in a number of different areas) is considered too far removed or unqualified to make patient care decisions and, based on survey comments, obstructive to physicians trying to advocate for their patients. The interference of elected officials was also considered a barrier to patient advocacy (see Appendix IV).

The most alarming finding from the comparative analysis of the 2011 and 2014 surveys was what appears to be an increase in the identification of comments directly related to intimidation or inferring some state of intimidation against physicians engaged in patient advocacy within the health system. Despite being reported in the media[4,5] in 2012, the issue of physician intimidation remains, judging by the analysis of comments from the 2014 survey, a major concern for physicians trying to advocate for their patients.

Training and education for physicians in patient advocacy was a key theme identified from both surveys, suggesting that either little has been done or that the awareness of what is available remains low in this area from 2011 to 2014. It was recommended that training and education be extended to administrators and leaders within the health system to facilitate a better understanding of the concept and how best to support physicians and patients.

APPENDICES

APPENDIX I: 2014 ROLE AND PROCESS OF PHYSICIAN ADVOCACY SURVEY

HQCA

Role and Process of Physician Advocacy Questionnaire

Taking part in this survey is voluntary

Completing the questionnaire

For each question, please fill-in one bubble, using a black or blue pen, or a soft-led pencil. Don't worry if you make a mistake; simply cross out or erase the mistake, and fill-in the correct bubble.

Sometimes you will find the bubble you have filled-in has an instruction to go to another question. For example: ○Yes [Go to 12]

By following the instructions, you will only complete questions that apply to you.

Completing the questionnaire online

If you would rather complete this survey online, you can do so at: www.prasurveys.com/HQCA.

This secure site will require you to enter your unique passcode, which can be found on the letter enclosed with this survey. This code is used only to manage the survey process and to validate participation.

If you do not wish to participate in this survey, you can do so by simply contacting the Project Manager at PRA Inc. below.

Questions or help?

If you have any questions, please call Nicholas Borodenko of PRA Inc. at 1-888-877-6744 or by email at HQCAsurvey@pra.ca.

Your answers will be confidential and anonymous.

The information you provide will be kept strictly confidential and will only be used and/or disclosed in aggregate form. Individual survey responses will not be shared with anyone. The information is collected under the authority of the Health Quality Council of Alberta Regulation 130/2006, section 13.

ABOUT PHYSICIAN ADVOCACY

The Royal College of Physicians & Surgeons of Canada states in their CanMEDS 2005 Physicians Competency Framework that: "as health advocates, physicians responsibly use their expertise and influence to advance the health and well being of individual patients, communities and populations":

As you read the questions below, please answer them within the context of how you perceive advocacy, such as patients, families, communities or greater system changes.

1. Do you believe that it is your professional responsibility to act on behalf of patients to advance the care and well-being of: ***(Fill in all that apply)***
   - ○ My individual patient
   - ○ My clincial population of patients
   - ○ Populations within the broader community
   - ○ Other ***(Please specify)*** _____

2. Have you ever received any professional education or training with respect to advocacy for patients? ***(Fill in all that apply)***
   - ○ No, have had no training in advocacy
   - ○ Yes, in medical school
   - ○ Yes, in residency
   - ○ Yes, as continuing medical education (CME)
   - ○ Yes, on-the-job training
   - ○ Yes, peer mentorship
   - ○ Yes, other ***(Please specify)*** _____

3. In the past year, have you used any of the following sources for information on physician advocacy? ***(Fill in all that apply)***
   - ○ College of Physicians & Surgeons of Alberta
   - ○ Alberta Medical Association
   - ○ Canadian Medical Association
   - ○ Alberta Health Services
   - ○ Physician Advocacy Assistance Line
   - ○ Canadian Medical Protective Association (CMPA)
   - ○ Royal College of Physicians & Surgeons of Canada
   - ○ Medical journals or other literature
   - ○ College of Family Physicians
   - ○ Other ***(Please specify)*** _____
   - ○ None of the above

4. Do you believe you have the necessary skills to effectively advocate for your patients?
   - ○ Yes ○ No ○ Don't Know

4.1. What skills, knowledge, or experience do you believe are necessary to effectively advocate for your patients?
   - ○ Experience advocating for patients in the past
   - ○ Knowledge of medical staff structure
   - ○ Knowing who to communicate with
   - ○ Knowledge of relevant codes of conduct, bylaws, regulations, and policies
   - ○ Experience with medical ethics
   - ○ Networking skills
   - ○ Social media skills
   - ○ Other ***(Please specify)*** _____
   - ○ None of the above

4.2. What "supports" might be helpful for you to be an effective patient advocate?
   - ○ Physician management courses on advocacy
   - ○ Access to a physician colleague or mentor experienced with the advocacy process
   - ○ Clear documentation of the advocacy process and related issues in your work context
   - ○ Clear organizational statement of policy regarding extent of support for advocacy for patients
   - ○ Access to a professional patient advocate who can stay on top of the process once the need is documented
   - ○ Other ***(Please specify)*** _____
   - ○ None of the above

5. In the past year, how often have you experienced care delivery issues that negatively impacted the care of your patients? (These might include quality, safety, resource, or policy related issues)?
   - ○ Never ○ Sometimes ○ Usually ○ Always

6. Considering your usual work context in the past year, is there a process through which you can advocate for your patients to address such issues as:

1) Quality	○ Yes	○ No	○ Don't Know
2) Safety	○ Yes	○ No	○ Don't Know
3) Resource issues	○ Yes	○ No	○ Don't Know
4) Policy issues	○ Yes	○ No	○ Don't Know

7. If you were a physician under contract, in the past year has your "contract" ...
   - ○ Limited your ability to advocate for your patients in any way
   - ○ Enhanced your ability to advocate for your patients in any way
   - ○ Contract does not address advocacy directly
   - ○ I did not work under contract

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8. If you work within a healthcare delivery organization; In the past year, have organizational policies ...
   - ○ Limited your ability to advocate for your patients in any way
   - ○ Enhanced your ability to advocate for your patients in any way
   - ○ Organizational policies do not address advocacy directly
   - ○ I did not work in an organization

9. In the past year, has your ability to advocate on behalf of your patients been limited in any way?
   - ○ Yes
   - ○ No ***(If 'No,' go to Q12)***

10. Which of the following (if any) have restricted your ability to effectively advocate on behalf of your patients: ***(Fill in all that apply)***
    - ○ My lack of training and education in advocacy
    - ○ My inexperience in advocating for my patients
    - ○ Uncertainty of my role as an advocate
    - ○ Lack of time to advocate
    - ○ Inadequate communication between providers
    - ○ Unclear process for advocacy
    - ○ Unsupportive or unresponsive organizational policies, structure, or culture
    - ○ Lack of resources to provide requested care
    - ○ Conflict over best course of care
    - ○ Threat of intimidation, retaliation, or reprisal
    - ○ Other ***(Please specify)*** _____

11. Who of the following (if any) has restricted your ability to advocate for your patients? ***(Fill in all that apply)***
    - ○ Physician peers
    - ○ Department or division administration
    - ○ Organization administration
    - ○ Organization leadership or executive
    - ○ Alberta Health and Wellness
    - ○ College of Physicians & Surgeons of Alberta
    - ○ Alberta Medical Association
    - ○ Alberta Health Services
    - ○ Other healthcare professionals (e.g., nurses, pharmacists, paramedics, etc.)
    - ○ Social and community services (e.g., Workers' Compensation, AISH, Child and Family Services, etc.)
    - ○ Other ***(Please specify)*** _____

12. Which of the following (if any) have enhanced your ability to effectively advocate on behalf of your patients: ***(Fill in all that apply)***
    - ○ My training and education in advocacy
    - ○ My experience in advocating for my patients
    - ○ Supportive organizational policies
    - ○ A clear process for advocacy where I work
    - ○ A clear understanding of physician advocacy role where I work
    - ○ Available resources to provide requested care
    - ○ Agreement on the best course of care
    - ○ Other ***(Please specify)*** _____
    - ○ None of the above

13. Who of the following (if any) has enhanced your ability to advocate for your patients? ***(Fill in all that apply)***
    - ○ A mentor
    - ○ Physician peers
    - ○ Department or division administration
    - ○ Non-physician organizational leadership
    - ○ Alberta Health and Wellness
    - ○ Royal College of Physicians and Surgeons
    - ○ Alberta Medical Association
    - ○ Alberta Health Services
    - ○ College of Physicians and Surgeons of Alberta
    - ○ Zone Medical Staff Associations
    - ○ Canadian Medical Protective Association (CPMA)
    - ○ College of Family Physicians
    - ○ Physician Advocacy Assistance Line
    - ○ Other healthcare professionals (e.g., nurses, pharmacists, paramedics, etc.)
    - ○ Other ***(Please specify)*** _____
    - ○ None of the above

14. In the past year, how often have you stopped yourself from advocating for your patients because you felt that nothing would happen to address the issue?
    ○ Never ○ Sometimes ○ Usually ○ Always

15. In the past year, how often have you stopped yourself from advocating for your patients for fear of negative repercussions for you as a physician?
    ○ Never ○ Sometimes ○ Usually ○ Always

16 In the past year, how often have you advocated for the needs of your patients? ***(If 'Never,' go to Q24 on page 4)***
    ○ Never ○ Sometimes ○ Usually ○ Always

17. In the past year, how often have your suggestions been acted upon in a meaningful way when you advocated for your patients?
O Never O Sometimes O Usually O Always

18 In the past year, how often has your role as an advocate for patients had a positive outcome for your patients?
O Never O Sometimes O Usually O Always

19. In the past year, how often has your role as an advocate for patients had a positive outcome for you as a physician?
O Never O Sometimes O Usually O Always

20. In the past year, to whom have you advocated for the needs of your patients? ***(Fill in all that apply)***
- O Physician peers or colleagues
- O Your department or division (within organization)
- O The executive of your healthcare organization
- O Alberta Health and Wellness
- O Public media (news, reporters, etc)
- O Politicians, MLAs, or related bodies
- O Alberta Medical Association
- O Canadian Medical Association
- O College of Physicians & Surgeons of Alberta
- O Alberta Health Services
- O Other healthcare professionals (e.g., nurses, pharmacists, paramedics, etc.)
- O Social and community services (e.g., Workers' Compensation, AISH, Child and Family Services, etc.)
- O Other ***(Please specify)*** [ ]
- O None of the above

21. In the past year, considering your professional responsibility for advocacy, which best describes your experience?
- O Greatly supported
- O Somewhat supported
- O Neither supported or obstructed
- O Somewhat obstructed
- O Greatly obstructed

22. In the past year, have you experienced any of the following when advocating for the needs or your patients? ***(Fill in all that apply)***
- O Ignored
- O Unsupported
- O Pressured to withdraw your request
- O Censored
- O Intimidated
- O Punished
- O Threatened
- O Other ***(Please specify)*** [ ]
- O None of the above

23. In the past year, have you experienced any positive support when advocating on behalf of your patients? ***Please describe.***

[ ]
[ ]
[ ]
[ ]
[ ]
[ ]

ABOUT YOU

24. Have you actively practiced medicine in the past 12 months?
O Yes O No

25. Are you male or female?
O Male O Female

26. What was your year of graduation from medical school?
(Please write in) e.g., 1 9 3 4
[ ][ ][ ][ ]

[ ]

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27. What is your physician specialty?

- O GP or Family Physician
- O Other *(Please specify)* ☐

28. In which of the following areas do you presently work? ***(Fill in all that apply)***:

- O Community based (primary) care
- O Community based (specialty) care
- O Hospital based - inpatient
- O Hospital based - outpatient
- O Emergency department or urgent care
- O Other *(Please specify)* ☐

29. In which Alberta Health Services zone do you primarily practice? (Regardless of work type)

- O South Zone
- O Calgary Zone
- O Central Zone
- O Edmonton Zone
- O North Zone

30. Are you under contract to provide services within or under a care provider organization or corporation?

- O Yes ☐ *(If 'yes,' please specify organization)*
- O No

31. Which of the following describe the ways in which you are paid for your clinical work? ***(Fill in all that apply)***:

- O Fee for service
- O Clinical Alternative Relationship Plan
- O Academic Alternative Relationship Plan
- O Hourly rate (other than Alternative Relationship Plan)
- O Community Alternative Relationship Plan
- O Other *(Please specify)* ☐

32. Can we contact you again if we have questions about your responses? If yes, please provide your

Name: _____

Phone number: _____

33. Do you have any additional comments, concerns or suggestions regarding physician advocacy issues as you have experienced them in your practice? ***(Please specify below)***

THANK YOU FOR YOUR ASSISTANCE

Please return using the pre-paid envelope provided to you.

APPENDIX II: 2014 ROLE AND PROCESS OF PHYSICIAN ADVOCACY SURVEY RECRUITMENT MATERIALS

Physician Final Letter

<SURVEY NUMBER>

Dear Dr. <FIRST> <LAST>:

We recently sent you a survey the Health Quality Council of Alberta (HQCA) is conducting on the role and process of physician advocacy. Both the Alberta Medical Association and the College of Physicians & Surgeons of Alberta support and encourage participation in this survey.

The important information you and other physicians provide will allow us to better understand physician knowledge and experience related to advocacy in Alberta, and the extent to which your advocacy for patient care is supported by healthcare provider organizations, government, professional colleges and others. This survey is a repeat of our 2011 survey of physicians, which was part of an independent review focused on *The Role and Process of Physician Advocacy*. A number of actions have been taken by Alberta Health Services to address the issue of physician advocacy and intimidation, and your input will help us to assess whether perceptions of physician advocacy have changed, potentially in response to these actions. The survey will be conducted independently and the findings will be made publicly available, as they were with the previous survey.

Your views are important, and as we have not received your response, we are providing you with a second copy of the questionnaire. If you have already replied, please ignore this letter and accept our thanks for your participation.

Your participation is voluntary and you need not answer all of the questions. We hope you will participate and provide as much information as possible. Your answers will be kept strictly confidential and will be combined with those of other physicians in the final report. Individual survey answers will not be shared with anyone.

The questionnaire should take about 10 minutes to complete. Once complete, please return it in the enclosed pre-paid return envelope or fax it to PRA at their toll-free at 1-800-717-6744.

You may also choose to complete the survey online at www.prasurveys.com/HQCA. This secure site will require you to enter your unique passcode code. This code is used only to manage the survey process and to verify legitimate participation. Your passcode is shown below.

PASSCODE: <PASSCODE>

If you would like more information about the survey or have questions on how to complete the questionnaire, please do not hesitate to call Nicholas Borodenko of PRA at 1-888-877-6744 or by email at HQCAsurvey@pra.ca.

Thank you in advance for your participation.

Sincerely,

Andrew Neuner, MBA, MA, CHE

Chief Executive Officer

Health Quality Council of Alberta

The HQCA has a legislated mandate under the *Health Quality Council of Alberta Act* to promote and improve patient safety and health service quality in Alberta. Part of this mandate includes monitoring and reporting on the quality and safety of the healthcare system.

Physician Advocacy Reminder Postcard

HQCA
Health Quality Council of Alberta

<SURVEY NUMBER>
DR. <FIRST> <LAST>
<ADDRESS1>
<ADDRESS2>
<CITY>, <PROV> <POSTAL CODE>

Recently the Health Quality Council of Alberta sent you a questionnaire. If you have already completed and returned it to us, please accept our sincere thanks. If not, please do so at your earliest convenience.

The number of physicians likely to participate in the survey is small so it is important that your responses are included.

The information collected from this study will assist us to establish a better understanding of physician advocacy roles, and the extent to which your advocacy for patient care is supported by healthcare provider organizations, government, professional colleges and others.

If, by some chance, you did not receive the questionnaire or it was misplaced, please contact Nicholas Borodenko of PRA Inc. at 1-888-877-6744 or by email at HQCAsurvey@pra.ca and another package will be sent to you.

Sincerely,

Andrew Neuner, MBA, MA, CHE
Chief Executive Officer
Health Quality Council of Alberta

Physician Advocacy Introduction

<SURVEY NUMBER>

Dear Dr. <FIRST> <LAST>:

I would like to invite you to participate in a confidential survey about the role and process of physician advocacy in Alberta. The Health Quality Council of Alberta (HQCA) is repeating our 2011 survey of physicians, which was part of an independent review focused on *The Role and Process of Physician Advocacy*. Both the Alberta Medical Association and the College of Physicians & Surgeons of Alberta support and encourage participation in this survey.

In response to recommendations made by the HQCA as a result of the 2011 survey, a number of actions have been taken by Alberta Health Services to address the issue of physician advocacy and intimidation. To assess whether perceptions of physician advocacy have changed, potentially in response to AHS actions, the AHS CMO Provincial Medical Affairs has asked the HQCA to repeat the survey. We have agreed with the understanding that the HQCA's work will be conducted independently and that the HQCA's findings will be fully transparent and made publicly available, as they were with the previous survey. While funding to complete this work has been provided by AHS, the HQCA will maintain independent control of the process and outputs.

The important information you and other physicians provide will allow us to better understand physician knowledge and experience related to advocacy in Alberta, and the extent to which your advocacy for patient care is supported by healthcare provider organizations, government, professional colleges and others. Physician experience with advocacy in 2014 will be compared with physician experience in 2011, to assess the potential impact of strategies to support physician advocacy.

Your participation is voluntary and you need not answer all of the questions. We hope you will participate and provide as much information as possible. Your answers will be kept strictly confidential and will be combined with those of other physicians in the final report. Individual survey answers will not be shared with anyone.

To manage the survey process and to ensure confidentiality, the HQCA has engaged Prairie Research Associates (PRA) Inc. PRA is an independent, national research firm that is under contract to the HQCA to conduct the survey according to Alberta privacy legislation.

The questionnaire should take about 10 minutes to complete. Once complete, please return it in the enclosed pre-paid return envelope or fax it to PRA at their toll-free at 1-800-717-6744.

You may also choose to complete the survey online at www.pra.ca/en/advocacysurvey. This secure site will require you to enter your unique passcode code. This code is used only to manage the survey process and to verify legitimate participation. Your passcode is shown below.

PASSCODE: <PASSCODE>

We would appreciate it if you would take the time now to complete and return your questionnaire. If we do not receive anything from you soon, you may receive a reminder notice by mail. If you would like more information about the survey or have questions on how to complete the questionnaire, please do not hesitate to call Nicholas Borodenko of PRA at 1-888-877-6744 or by email at HQCAsurvey@pra.ca.

Thank you in advance for your participation.

Sincerely,

Andrew Neuner, MBA, MA, CHE

Chief Executive Officer

Health Quality Council of Alberta

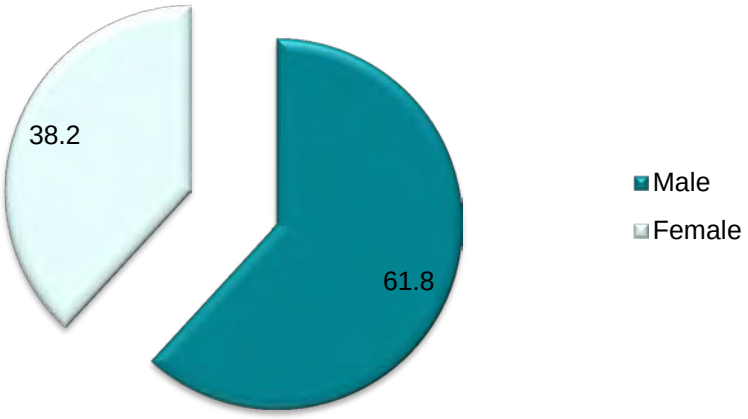
The HQCA has a legislated mandate under the *Health Quality Council of Alberta Act* to promote and improve patient safety and health service quality in Alberta. Part of this mandate includes monitoring and reporting on the quality and safety of the healthcare system.

APPENDIX III: SURVEY RESPONDENT CHARACTERISTICS

2014 Respondent characteristics

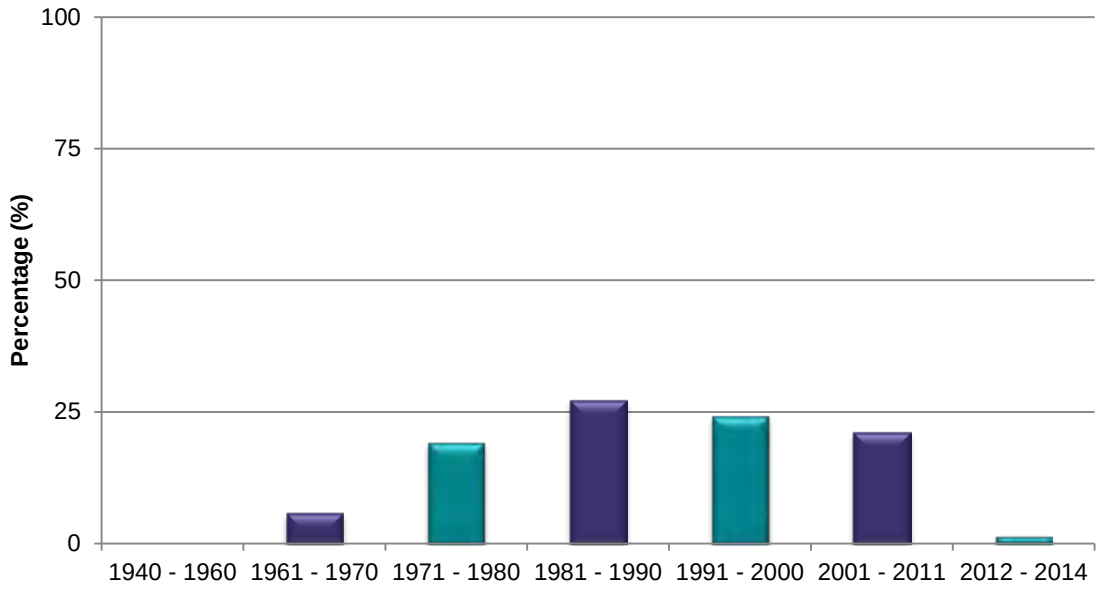
Of the 1,754 physicians who responded to the 2014 survey, 61.8 per cent were male and 38.2 per cent were female. Slightly less than two thirds (70.6%) graduated from medical school between 1971 and 2000. Only 21.1 per cent physicians graduated between 2001 and 2011; and only 5.8 per cent graduated between 1961 and 1970. A small number of respondents (<1%) indicated they were retired.

Figure 28: Gender distribution[xiii]



[xiii] Sample gender distribution for the 2014 *Role and Process of Physician Advocacy* survey is consistent with other Canadian surveys of physicians. For example, in 2013 and 2014, the National Physician Survey Alberta sample gender distributions were 59.8 per cent male (40.1% female) and 59.1 per cent male (41.0% female), respectively.

Figure 29: Year of medical school graduation



Over half of respondents (55.6%) reported a medical specialty other than General Practice (GP), whereas 44.4 per cent reported they were a GP or Family Physician. Physicians with specialized training were asked to provide their specialty as an open-ended response. Almost 40 specialties were coded from this information; most with small proportions of respondents – shown below as Other Specialists (39.0%). Emergency Medicine and Anesthesia accounted for 2.2 per cent and 3.7 per cent of respondents, respectively; General Internal Medicine (2.7%); Mental Health (5.3%); Orthopedic Surgery and General Surgery combined (2.5%); and Pedatrics, including pediatric emergency and mental health, accounted for 4.0 per cent.

Figure 30: General practice versus specialists

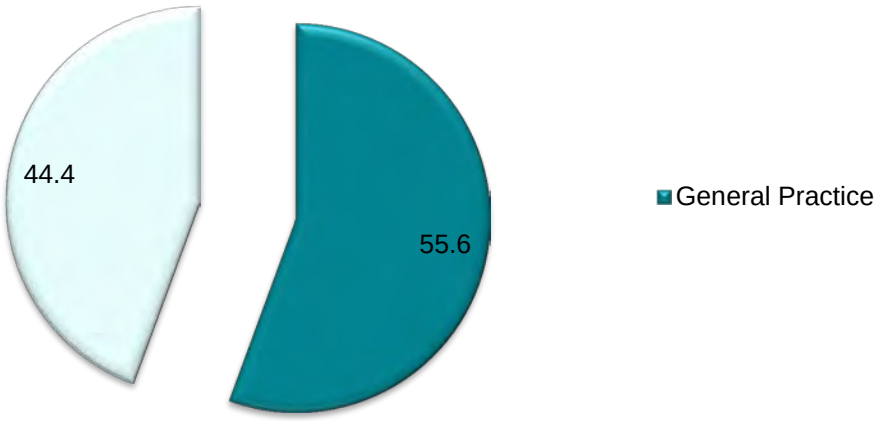
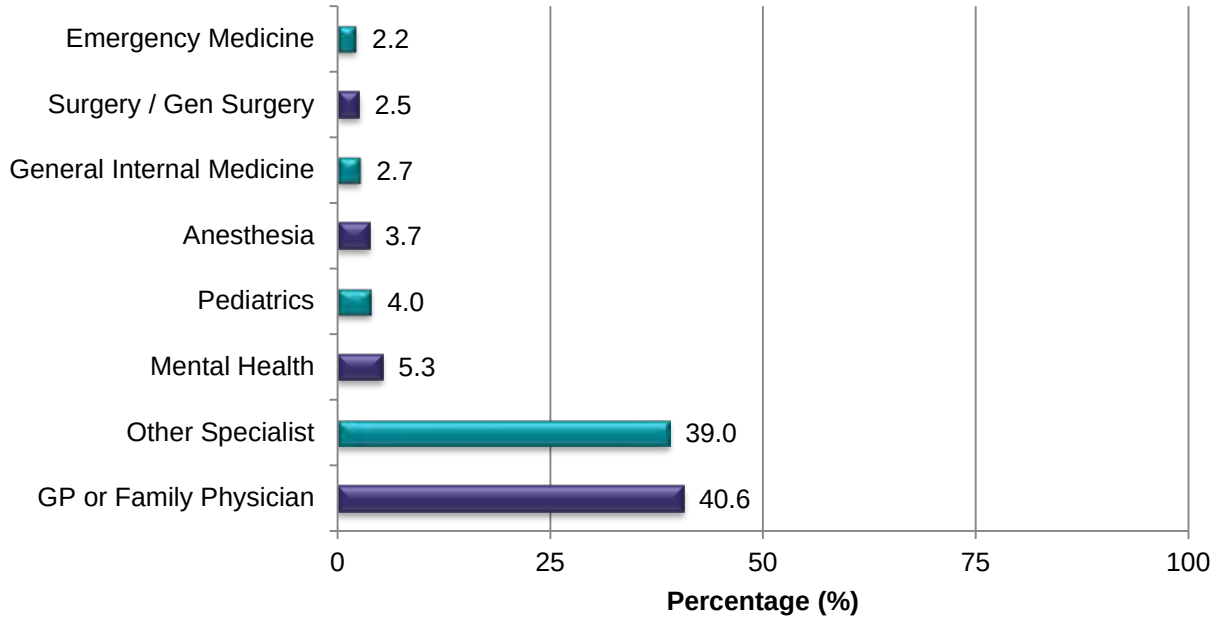


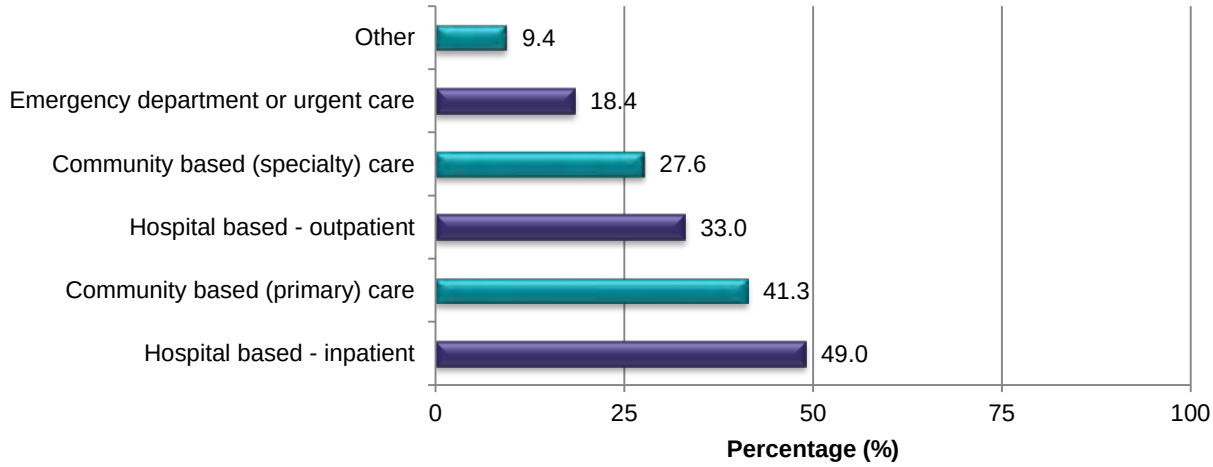
Figure 31: Physician specialties



Work setting was reported in five closed ended response categories, as well as an open ended response for "other" work settings. Multiple work settings were permitted.[xiv] Hospital based inpatient settings were reported by 49.0 per cent of respondents; 33.0 per cent reported working in a hospital based outpatient setting; and 27.6 per cent reported working in community based speciality care. Community based primary care was reported by 41.3 per cent, and emergency department or urgent care by 18.4 per cent of respondents. The majority of respondents (77.5%) reported they were paid fee for service, wheras 25.1 per cent reported they were paid under an alternative relationship plan (ARP). An hourly rate was reported by 5.9 per cent and various other arangements by 7.5 per cent of respondents.

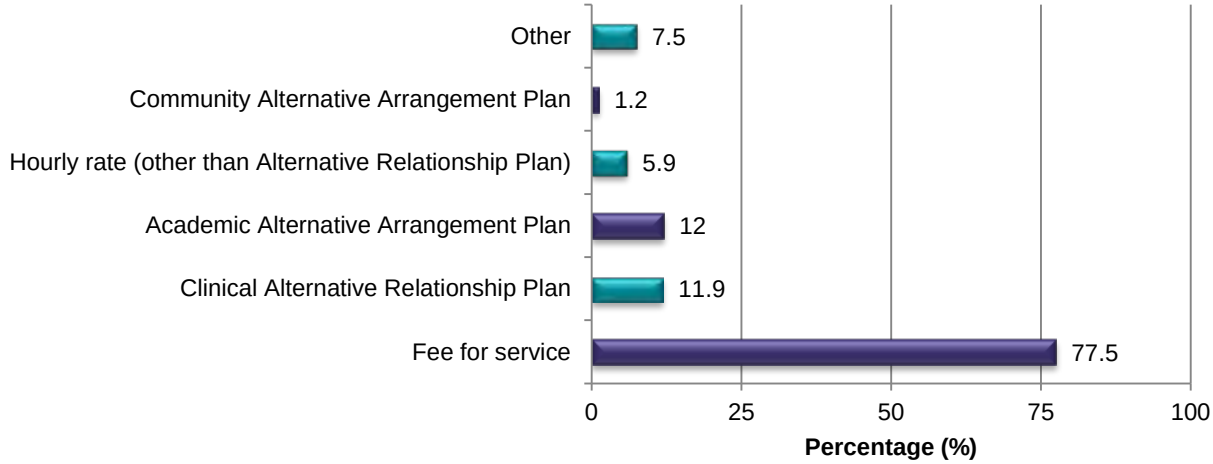
[xiv] Proportions sum to greater than 100 per cent because many physicians work in multiple settings.

Figure 32: Work setting



Note: Respondents could choose more than one answer. Totals sum to more than 100 per cent.

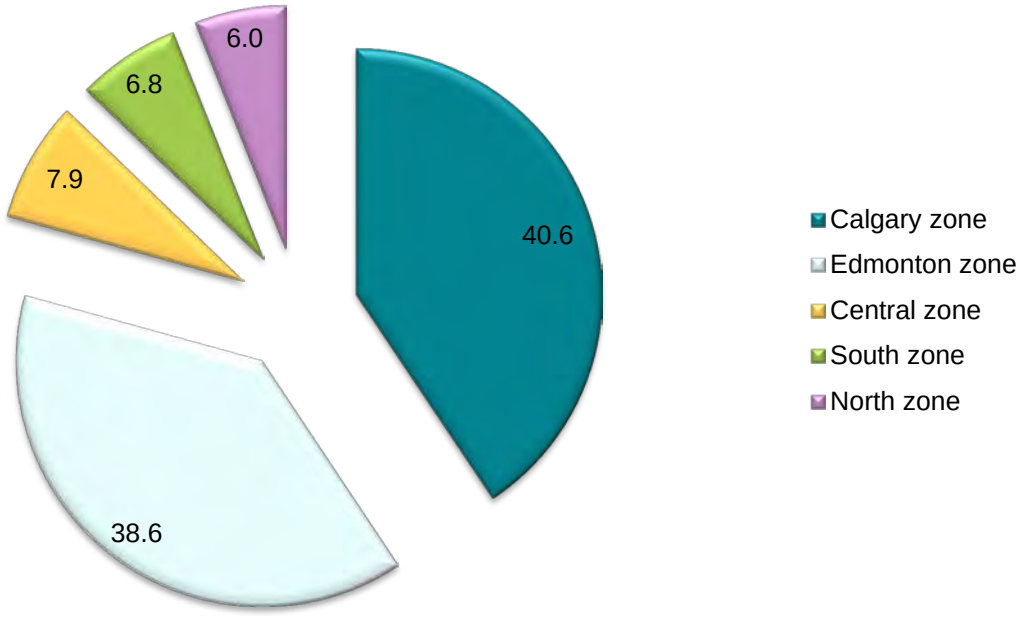
Figure 33: Payment Type



Note: Respondents could choose more than one answer. Totals sum to more than 100 per cent.

The majority of physicians reported working in the geographic area of either the Calgary zone (40.6%) or the Edmonton zone (38.6%); with the remainder in the Central zone (7.9%), South zone (6.8%) and the North zone (6.0%).

Figure 34: Alberta Health Services zones



APPENDIX IV: REGRESSION ANALYSES – RESULTS FOR INDIVIDUAL TYPES OF HARM[xv]

In the past year, has the physician been ignored when advocating for their patients? (Q22a)

Specialists who advocated for the needs of their patients to their organizational department or division within the past year were 36.6 per cent more likely to have felt ignored, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 31.9 per cent more times as likely to have felt ignored, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health Services within the past year were 28.2 per cent more likely to have felt ignored, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Male specialists were 20.2 per cent more likely to have felt ignored within the past year as compared to female specialists; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to their physician peers or colleagues within the past year were 33.5 per cent more likely to have felt ignored as compared with other family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health within the past year were 30.1 per cent more likely to have felt ignored as compared with other family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to social and community services including Workers' Compensation, Assured Income for the Severely Handicapped (AISH), and Child and Family Services within the past year were 28.7 per cent more likely to have felt ignored as compared with other family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who worked in the AHS North zone were 44.1 per cent less likely to have felt ignored within the past year as compared to family physicians who worked in the Calgary zone.

In the past year, has the physician been unsupported when advocating for their patients? (Q22b)

Specialists who advocated for the needs of their patients to their physician peers or colleagues within the past year were 17.1 per cent more as likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to their organizational department or division within the past year were 44.7 per cent more likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

[xv] Regression results are available upon request.

Specialists who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 33.8 per cent more likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health within the past year were 15.4 per cent more likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the Canadian Medical Association within the past year were 42.1 per cent less likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health Services within the past year were 24.3 per cent more likely to have felt unsupported, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who were on a fee for services pay structure were 16.9 per cent less likely to have felt unsupported, as compared with specialists who were working under an alternative relationship plan; controlling for all independent variables.

Family physicians who worked in AHS North zone were 30.1 per cent less likely to have felt unsupported, as compared with family physicians who worked in the Calgary zone; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to their physician peers or colleagues within the past year were 57.4 per cent more likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to their organizational department or division within the past year were 23.8 per cent likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health within the past year were 26.5 per cent more likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the Alberta Medical Association within the past year were 33.2 per cent more likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to other healthcare professionals (e.g., nurses, pharmacists, paramedics) within the past year were 30.7 per cent more likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to social and community services (e.g., Workers' Compensation, AISH, Child and Family Services) within the past year were 34.1 per cent more likely to have felt unsupported, as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who worked in community based specialty care within the past year were 39.7 per cent less likely to have felt unsupported, as compared with family physicians who worked elsewhere (i.e., other); controlling for all independent variables.

In the past year, has the physician been pressured to withdraw their request when advocating for their patients? (Q22c)

Specialists who advocated for the needs of their patients to their organizational department or division within the past year were 76.9 per cent more likely to have felt pressured to withdraw their request, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 98.1 per cent more likely to have felt pressured to withdraw their request, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to politicians, MLAs, or related bodies within the past year were 92.3 per cent more likely to have felt pressured to withdraw their request, as compared with specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who worked under a clinical alternative work arrangement within the past year were 82.5 per cent more likely to have felt pressured to withdraw their request, as compared with specialists who were working under other fee payment plans; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to their organizational department or division within the past year were 97.8 per cent more likely to have felt pressured to withdraw their request as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health within the past year were 86.2 per cent more likely to have felt pressured to withdraw their request as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the Canadian Medical Association within the past year were 306.5 per cent more likely to have felt pressured to withdraw their request as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health Services within the past year were 114.0 per cent more likely to have felt pressured to withdraw their request as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to social and community services (e.g., Workers' Compensation, AISH, Child and Family Services) within the past year were 138.9 per cent more likely to have felt pressured to withdraw their request as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

In the past year, has the physician been censored when advocating for their patients? (Q22d)

Specialists who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 179.0 per cent more likely to have felt censored, within the past year compared to specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who worked in hospital based inpatient care were 167.6 per cent more likely to have felt censored than specialists who worked elsewhere (i.e., other); controlling for all independent variables.

Specialists who worked in emergency or urgent care were 374.5 per cent more likely to have felt censored than specialists who worked elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 137.6 per cent more likely to have felt censored as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the Canadian Medical Association within the past year were 343.4 per cent more likely to have felt censored as compared with family physicians who advocated elsewhere; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the College of Physicians and Surgeons of Alberta within the past year were 188.9 per cent more likely to have felt censored as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who worked in hospital based outpatient care were 372.6 per cent more likely to have felt censored than family physicians who worked elsewhere (i.e., other); controlling for all independent variables.

For every additional year practice experience, family physicians were 0.03 per cent less likely to have felt intimidated within the past year; controlling for all independent variables.

In the past year, has the physician been intimidated when advocating for their patients? (Q22e)

Specialists who advocated for the needs of their patients to their organizational department or division within the past year were 205.5 per cent more likely to have felt intimidated, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 52.4 per cent more likely to have felt intimidated, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health within the past year were 55.2 per cent more likely to have felt intimidated, than specialists who advocated elsewhere; controlling for all independent variables.

Specialists who advocated for the needs of their patients to politicians, MLAs, or related bodies within the past year were 65.0 per cent more likely to have felt intimidated, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health Services within the past year were 59.7 per cent more likely to have felt intimidated, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to social and community services (e.g., Workers' Compensation, AISH, Child and Family Services) within the past year were 61.9 per cent less likely to have felt intimidated, than specialists who advocated elsewhere; controlling for all independent variables.

Male specialists who advocated for the needs of their patients within the past year were 40.1 per cent less likely to have felt intimidated as compared with female specialists; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 100.8 per cent more likely to have felt intimidated as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health within the past year were 178.9 per cent more likely to have felt intimidated as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to Alberta Health Services within the past year were 90.9 per cent more likely to have felt intimidated as compared with family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who worked in hospital based inpatient care were 74.1 per cent more likely to have felt intimidated than family physicians who worked elsewhere (i.e., other); controlling for all independent variables.

Family physicians who worked in emergency or urgent care were 57.8 per cent less likely to have felt intimidated than family physicians who worked elsewhere (i.e., other); controlling for all independent variables.

For every additional year practice experience, family physicians were 0.03 per cent less likely to have felt intimidated within the past year; controlling for all independent variables.

In the past year, has the physician been punished when advocating for their patients? (Q22f)

Specialists who advocated for the needs of their patients to their organizational department or division, within the past year were 410.1 per cent more likely to have felt punished, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the executive of their health care organization within the past year were 230.4 per cent more likely to have felt punished, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health Services within the past year were 2.1 per cent likely to have felt punished, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to social and community services (Workers' Compensation, AISH, Child and Family Services) within the past year were 83.0 per cent less likely to

have felt punished, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists working in a community based primary care setting were 66.5 per cent less likely to report having been punished for advocating within the past year, as compared with specialists working in other settings; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the executive of their health care organization within the past year were 506.8 per cent more likely to have felt punished, than family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians being paid by an academic alternative relationship plan were 440.2 per cent more likely to report having been punished for advocating within the past year, as compared with family physicians working under other payment agreements; controlling for all independent variables.

In the past year, has the physician been threatened when advocating for their patients? (Q22g)

Specialists who advocated for the needs of their patients to their organizational department or division within the past year were 122.7 per cent more likely to have felt threatened, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to the executive of their health care organization within the past year were 129.6 per cent more likely to have felt threatened, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to Alberta Health Services within the past year were 196.7 per cent more likely to have felt threatened, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists who advocated for the needs of their patients to social and community services (Workers' Compensation, AISH, Child and Family Services) within the past year were 55.7 per cent less likely to have felt threatened, than specialists who advocated elsewhere (i.e., other); controlling for all independent variables.

Specialists working in a community based specialty care setting were 89.4 per cent more likely to report having been threatened for advocating within the past year, as compared with specialists working in other settings; controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the executive of their healthcare organization within the past year were 373.2 per cent more likely to have felt threatened, than family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the Canadian Medical Association within the past year were 581.0 per cent more likely to have felt threatened, than family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians who advocated for the needs of their patients to the College of Physicians and Surgeons of Alberta within the past year were 322.8 per cent more likely to have felt threatened, than family physicians who advocated elsewhere (i.e., other); controlling for all independent variables.

Family physicians working in a community based specialty care setting were 82.8 per cent less likely to report having been threatened for advocating within the past year, as compared with family physicians working in other settings; controlling for all independent variables.

Family physicians being paid on a fee for service plan were 687.0 per cent more likely to report having been punished for advocating within the past year, as compared with family physicians working under other payment agreements; controlling for all independent variables.

APPENDIX V: QUALITATIVE COMPARATIVE ANALYSES OF THE 2011 AND 2014 SURVEYS

From the 2011 survey, 478 comments to open-ended question 32 were coded and analyzed.

In 2014, there were 380 open-ended responses to question 33 of the survey of which 36 (9.5%) were considered no comment answers, leaving 344 comments to be coded and analyzed.

The themes identified in 2014 emerged from the analysis of the data prior to reviewing the 2011 survey report.[1] The 2014 themes were consistent with those documented from the 2011 analysis of comments, but were labelled somewhat differently.

Table 2: Comparative analyses of 2011 and 2014 surveys

2011 Themes	2014 Themes
Physicians' experience with advocacy and intimidation	Advocacy Intimidation
Challenges identified with advocacy	Advocacy Bureaucracy
Why Physicians chose not to advocate	Advocacy – Attitudes sub theme Training and Education Professional Relationships Patient Care Intimidation
Physician education on advocacy	Training and Education
Impact of Culture on advocacy	Bureaucracy Intimidation
Impact of restructuring of healthcare on advocacy	Bureaucracy Resources Patient Care
Enabling effective advocacy	Advocacy
Lines of Authority and accountability	Bureaucracy
Alberta Health Services	Bureaucracy
College of Physicians and Surgeons of Alberta	Professional Relationships
	Patient Care
	Resources

Analysis of the qualitative data from question 32 of the 2011 survey will henceforth be referred to as the 2011 survey. Analysis of the qualitative data from question 33 of the 2014 survey will henceforth be referred to as the 2014 survey.

The 2011 survey identified physicians' experiences with advocacy and intimidation, coded from the 2014 survey under the principle theme of Advocacy, which encompasses attitudes to advocacy, both positive and negative, solutions to challenges, and practices in place. Based on the number of comments from 2014 identifying intimidation, it was deemed a separate theme for analysis and interpretation.

In 2011, physicians' experiences with advocacy were described as positive from some respondents with no "witnessed negative issues related to physician advocacy". From the analysis of the comments from the 2014 survey, a sense of frustration, disillusionment, and in-action emerged from respondents. The ten comments identified as positive acknowledged patient advocacy as important or suggested signs of improvement. These were somewhat overshadowed by the 37 comments of a negative nature that were critical of the current state of physician advocacy for patients. However, 27 comments offered solutions to improve the state of patient advocacy and another 20 respondents were identified as actively practicing some form of patient advocacy.

Intimidation of physicians was identified in the 2011 survey but did not appear to be as much of a major issue as that identified in the 2014 survey. From the 2011 report *"a number of respondents had not experienced intimidation themselves but they described intimidation that happened to colleagues and its impact on those around them"* and some respondent comments reflected they had not witnessed negative issues *"related to physician advocacy"*, nor intimidation or obstruction. Over 20 per cent of all comments analyzed from the survey identify either avoidance to advocacy for patients based on fear of reprisal or descriptions of some form of intimidation. Forty comments articulated specific words to convey intimidation such as "threats", "bullied", "obstruction", "punitive actions", "abuse", "blame", "suffering", "marginalization", "harassment", and "discipline" and 66 descriptors of words, terms, or phrases used to describe intimidation emerged from the data.

The challenges identified with advocacy in the 2011 survey included challenges specific to poor workplace; lack of stable leadership, and concerns about management threats in AHS; challenges specific to specialists and access to care; lack of information as to how to access or where to access patient advocacy information; AHS managers and administrators being far removed from patient care; and concerns that patient care is not a priority over budgetary issues. These challenges are similar to those identified from the 2014 survey and emerge within a number of different themes. Concerns about leadership, access to information, managers and administrators being removed from patient care or not qualified in patient care, and budget issues emerged from the Bureaucracy theme. Challenges specific to specialists emerged from comments coded to the Professional Relationships theme and access to care arose as a major concern from comments coded in the Patient Care theme.

From the 2011 survey, the theme Why Physicians Chose Not to Advocate was identified. Barriers to physician advocacy were identified within AHS and its legal departments, the College of Physicians and Surgeons of Alberta (CPSA), and the Alberta Medical Association (AMA). Other documented reasons to not advocate included no training, disengagement, physician input not wanted, time commitment too much, reprisals for challenging the establishment, and continual advocacy without results causing "advocacy fatigue". Similar challenges were identified within different themes from the 2014 survey.

Comments analyzed within the Bureaucracy theme from the 2014 survey identified perceptions of the administration of the health system as obstructive, non-collaborative and unsupportive to physician advocacy for patients often resulting in perceived or accusations of intimidation. Government and/or political intervention and influence were also identified as barriers to patient advocacy. Within the Professional Relationships theme, 7.3 per cent of the 344 open responses to question 33 indicated a lack of support or confidence in professional regulatory bodies such as CPSA and AMA. Lack of training emerged from comments coded to the Training and Education theme, disengagement from the Advocacy – Attitudes sub- theme, lack of time for physician advocacy from the Patient Care theme, and reprisal emerged from the Intimidation theme.

Physician education on advocacy from the 2011 survey analysis aligns with the same issues identified in 2014 under Training and Education. Twelve per cent of total responses from the 2014 survey were coded to this theme and were in reference to advocacy training and education including mentorship, access to information and forms of support, guidance, or assistance.

Impact of Culture on advocacy was identified as a theme from the 2011 survey. Respondents commented on AHS promotional articles citing how well things were working in the healthcare system contrary to the reality of frontline perceptions. The 2011 report conveyed the culture "discourages advocacy" leading to a "culture of silence" with some physicians. From the 2014 survey, only six of the 344 (1.7%) comments analyzed used the term "culture" within the content of their submissions for question 33. Three of the comments were identified as Bureaucracy related and subsequently coded to that theme.

"Currently, I feel that I (+ physicians in general) are in a culture politically and organizationally which ignores the needs of the patient in favor of the needs of the system, i.e., Unresponsive."

The three other comments contained words also associated with Intimidation and were coded to that theme.

"It was unfortunate that the question of physician intimidation was changed to queue jumping by the former premiere as intimidation is a part of the medical culture, sadly."

The Impact of restructuring of healthcare on advocacy identified in the 2011 survey referenced "ineffectiveness", "duplication of services", "inability to balance resources", and substandard care "due to lack of resources" stemming from the restructuring of the health system. Similar issues referencing bureaucracy and the administration of AHS were identified in the 2014 survey comments but were coded under the Bureaucracy theme. A word search of the entire set of comments from question 33 of the 2014 survey revealed only one reference to reorganization and two references to restructuring. One comment requested no change to the health care system.

"No dramatic change to health care system please."

"The administration and management structure within AHS and (zone) Health needs restructuring, with a reduction in middle management positions. The layers of management and communication deficiencies which occur as a result are obstructive to advocacy and limit the efficiency of policy change in response to concerns."

"AHS seems to be too busy in a continual process or reorganization than to be responding to feedback for positive changes."

"The restructuring in AHS has been destructive to many processes and services. An example is the cutting of FTE, and doing without. This can be demoralizing to those who have to do more with less."

The 2011 analysis of qualitative data discussed Enabling Effective Advocacy providing suggestions for making advocacy more effective. In the 2014 survey, respondents provided similar suggestions and designated Solutions under the theme Advocacy.

The final theme that emerged from the 2011 survey, Lines of Authority and Accountability, described bureaucratic and political interference of elected officials, the frustrations with AHS, and the fear associated with CPSA. The analysis of the 2014 data identified the similar theme Bureaucracy with similar results. Comments reflecting opinions regarding the CPSA were coded under the Professional

Relationships theme which also included comments directed at the Alberta Medical Association and the Royal College of Physicians and Surgeons of Canada. Where comments from the 2011 survey identified fear, intimidation, and perceived punishment by the CPSA, comments from the 2014 survey primarily identified a lack of support or confidence in the regulatory bodies, particularly CPSA, and also identified some negativity towards colleagues and peers emerging from interactions with both.

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