

Mabel username id:

Please write id shown on letter
if different from id above

MABEL

Medicine in Australia: Balancing Employment and Life

2012

Hospital Doctor Not Enrolled in a Specialty Training Program (Interns & Medical Officers)

enquiries@mabel.org.au

www.mabel.org.au

Telephone: 03 8344 2600

MABEL has been endorsed by:

Australasian Society of Career Medical Officers
 Confederation of Postgraduate Medical Education Councils
 Postgraduate Medical Council of Victoria
 Postgraduate Medical Council of South Australia
 Postgraduate Medical Council of Western Australia
 Postgraduate Medical Education Council of Queensland
 Postgraduate Medical Institute of Tasmania
 NSW Institute of Medical Education and Training
 Australian General Practice Training
 Australian General Practice Network
 General Practice Registrars Australia
 Australian Medical Council
 Royal Australian College of General Practitioners
 Royal Australasian College of Physicians
 Royal Australasian College of Surgeons
 Royal College of Pathologists of Australasia
 Royal Australian and New Zealand College of Ophthalmologists
 Royal Australian and New Zealand College of Radiologists
 Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Australia and New Zealand College of Anaesthetists
 Australasian College for Emergency Medicine
 Australasian College of Sports Physicians
 Joint Faculty of Intensive Care Medicine
 Australian College of Rural and Remote Medicine
 Australian Society of Anaesthetists
 Australia and New Zealand Society of Palliative Medicine
 Australian and New Zealand Society for Geriatric Medicine
 Australian Society of Plastic Surgeons
 Australian and New Zealand Intensive Care Society
 Internal Medicine Society of Australia and New Zealand
 Australian and New Zealand Society of Nephrology
 Australian Rheumatology Association
 Medical Oncology Group of Australia Incorporated
 Australian Healthcare and Hospitals Association
 Australian Private Hospitals Association
 Australian Orthopaedic Association
 Rural Doctors Association of Australia
 Rural Health Workforce Australia



THE UNIVERSITY OF
MELBOURNE



MELBOURNE INSTITUTE®
of Applied Economic and Social Research



MONASH University
Medicine, Nursing and Health Sciences

Space is provided at the end of this survey to make additional written comments.
 Please write responses in boxes provided using a dark pen. Check boxes can be ticked or crossed.

A About your current situation

1. Are you currently doing any clinical medical work in Australia?

- ¹ Yes – *If yes, please go to Section B below and complete the main survey*
² No – *Continue*

2. Are you permanently retired from all types of paid work?

- ¹ Yes – *As you are permanently retired from all types of paid work you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*
² No – *Continue*

3. Which of the following statements describe your current situation? (Tick all that apply)

- Doing medical work in Australia that is non-clinical (e.g. medico-legal, teaching, research, committee work)
 Maternity leave
 Home duties/childcare
 Enrolled as a student
 Extended leave (e.g. sick leave, long service leave)
 Working outside Australia in a clinical role
 Working outside Australia in a non-clinical, but medical role
 Working outside Australia in a non-medical role
 Doing non-medical work in Australia. Please state job title:

4. Do you intend to return to clinical medical work in Australia?

- ¹ Yes – *Please go to Section G and complete the final two sections of the survey*
² Unsure – *Please go to Section G and complete the final two sections of the survey*
³ No – *As you do not intend returning to clinical work in Australia you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*

B About your job satisfaction

5. Please indicate how satisfied or dissatisfied you are with each of the various aspects of your work as a doctor.

	Very Dissatisfied	Moderately Dissatisfied	Not Sure	Moderately Satisfied	Very Satisfied	N/A
Freedom to choose your own method of working	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Amount of variety in your work	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Physical working conditions	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Opportunities to use your abilities	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Your colleagues and fellow workers	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Recognition you get for good work	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Your hours of work	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Your remuneration	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Amount of responsibility you are given	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>
Taking everything into consideration, how do you feel about your job?	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>

6. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The balance between my personal and professional commitments is about right	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have a poor support network of other doctors like me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is difficult to take time off when I want to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My patients have unrealistic expectations about how I can help them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The majority of my patients have complex health and social problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have good support and supervision from qualified specialists	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
There is enough time for me to do personal study	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Research publications are important to progress my training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The hours I work are unpredictable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I often undertake tasks that somebody less qualified could do	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

7. Would you like to change your hours of work?

- 1 No
- 2 Yes, I'd like to increase my hours
- 3 Yes, I'd like to decrease my hours

8. Do you plan to apply for a place on a GP or other specialist training program in the future?

- 1 Yes
- 2 Unsure
- 3 No, I already have a place
- 4 No, I already have a GP/specialist qualification— Go to question 12
- 5 No— Go to question 12

9. What year do you expect to begin GP/specialist training?

Year

Don't know (Tick box)

10. Which specialist training course have you been accepted into/are you waiting to commence?

- | | |
|---|---|
| 1 <input type="checkbox"/> Not Applicable—I do not currently have a place | 2 <input type="checkbox"/> Internal medicine (adult medicine) |
| 3 <input type="checkbox"/> Paediatrics and Child Health | 4 <input type="checkbox"/> Occupational Medicine |
| 5 <input type="checkbox"/> Palliative Medicine | 6 <input type="checkbox"/> Public Health Medicine |
| 7 <input type="checkbox"/> Rehabilitation Medicine | 8 <input type="checkbox"/> Anaesthesia |
| 9 <input type="checkbox"/> Dermatology | 10 <input type="checkbox"/> Emergency Medicine |
| 11 <input type="checkbox"/> General Practice | 12 <input type="checkbox"/> Intensive Care Medicine |
| 13 <input type="checkbox"/> Medical Administration | 14 <input type="checkbox"/> Obstetrics and Gynaecology |
| 15 <input type="checkbox"/> Ophthalmology | 16 <input type="checkbox"/> Pathology |
| 17 <input type="checkbox"/> Psychiatry | 18 <input type="checkbox"/> Radiology |
| 19 <input type="checkbox"/> Surgery | |

11. Which specialty program listed in question 10 above would you most like to enrol in?

Please specify:

Not Applicable (Tick box)

C About the places where you work

12. Excluding on-call, for how many HOURS in your MOST RECENT USUAL WEEK at work did you undertake work in each of the following settings? (Include ALL of the work you do as a doctor) (If none, write 0)

	Actual hours per week
Public hospital (including psychiatric hospital)	[][] hrs/wk
Private hospital	[][] hrs/wk
Private medical practitioner's rooms or surgery	[][] hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.)	[][] hrs/wk
Tertiary education institution	[][] hrs/wk
Other	[][] hrs/wk
TOTAL HOURS WORKED	[][] hrs/wk

13. What is the main hospital in which you work (i.e. spend most time)?

Hospital name []

Postcode [][][][]

14. How long have you worked at this hospital?

No. of years [][]

No. of months [][]

15. What is your salaried position?

- Intern
- CMO
- HMO Yr 1
- HMO Yr 2
- HMO Yr 3
- Other hospital medical officer

D About your workload

16. Excluding on-call, how many HOURS in your MOST RECENT USUAL WEEK at work did you spend on the following activities? (Include ALL of the work you do as a doctor in ALL jobs/workplaces) (If none, write 0)

TOTAL HOURS WORKED PER WEEK (Should equal the TOTAL in question 12)	[][] hrs/wk
Direct patient care (face-to-face, phone consultations, home visits)	[][] hrs/wk
Indirect patient care (medical notes, reports, phone calls, meeting patients' families)	[][] hrs/wk
Education activities (academic research, continuing medical education)	[][] hrs/wk
Management and administration	[][] hrs/wk
Other	[][] hrs/wk

17. In your most recent USUAL week at work, for around HOW MANY patients did you provide care? (Include face-to-face, out of hours and telephone consultations in ALL SETTINGS) (If none, write 0)

[][][]

18. Do you do any on-call yourself? (Including public holidays, weekends and weekdays outside of 8am to 6pm)

- Yes
- No—Go to question 21

19. In your last usual week at work: (If none, write 0)

How many HOURS were you rostered or listed for after hours and on-call? [][] hrs/wk

How many of these HOURS were actually spent in direct patient care? [][] hrs/wk

How many TIMES were you actually called out? [][] times/wk

20. In your most recent usual month, what was your on-call ratio? (For example, if it is 1 in 8, write 8 in the box provided.)

1 in

Not Applicable (Tick box)

21. Turning to time spent away from work: (If none, write 0)

How many WEEKS holiday did you take in the past year? weeks

How many WEEKS of parental or maternity leave did you take in the past year? weeks

Approximately how many DAYS off work due to illness did you have in the past year? days

Approximately how many DAYS off work did you have for other reasons in the past year? days

E About your finances

The following information will be used to examine the effect of financial issues on your work–life balance, and will remain strictly confidential.

22. What are your (approximate) TOTAL personal earnings from ALL of the work you do as a doctor? (If possible, base this on your last personal income tax return or payslip) Please write in ONE COLUMN where you have the most accurate information and can best remember.

	Annual	OR	Fortnightly
Before tax (gross earnings) \$	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>		<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
After tax (net earnings) \$	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>		<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>

23. In addition to this, did you receive any ongoing 'in kind' benefits or subsidies as part of your your current job/s (e.g. car, house, school fees, salary packaging)?

¹ Yes

² No

24. What is the approximate annual total value in dollars of these benefits? (If zero, write 0)

25. What is the total level of financial debt that you currently have as a result of your medical education and training? (Give dollar amount; include HECS debt, other debt associated with training and living expenses) (If zero, write 0)

\$

Don't Know (Tick box)

26. How much (in dollars) did you pay for professional medical liability, or malpractice, insurance premiums in the last year? (If this was provided by someone else on your behalf, write 0)

27. Do you have other sources of personal income apart from your medical work? (Profit from other business interests, dividend income, bank interest, rental income etc.)

¹ Yes

² No

28. What is your total gross and net HOUSEHOLD income? (Include your and your partner's earnings, income from other business interests, dividends, interest etc.) The figures below should be equal to or greater than your personal earnings provided in question 22. Please write in ONE COLUMN ONLY, where you have the most accurate information or can best remember.

	Annual	OR	Fortnightly
Before tax (gross household income) \$	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>		<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
After tax (net household income) \$	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>		<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>

F About your geographic location

29. Where is your main place of work?

Town/Suburb
 Postcode

30. How long have you been working in or close to this geographic location?

No. of years
 No. of months

31. Where do you live?

Town/Suburb
 Postcode

32. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I don't have many friends or family members in my current work location	1 <input style="width: 20px; height: 20px;" type="checkbox"/>	2 <input style="width: 20px; height: 20px;" type="checkbox"/>	3 <input style="width: 20px; height: 20px;" type="checkbox"/>	4 <input style="width: 20px; height: 20px;" type="checkbox"/>	5 <input style="width: 20px; height: 20px;" type="checkbox"/>	6 <input style="width: 20px; height: 20px;" type="checkbox"/>
It is easy to pursue my hobbies and leisure interests in my current work location	1 <input style="width: 20px; height: 20px;" type="checkbox"/>	2 <input style="width: 20px; height: 20px;" type="checkbox"/>	3 <input style="width: 20px; height: 20px;" type="checkbox"/>	4 <input style="width: 20px; height: 20px;" type="checkbox"/>	5 <input style="width: 20px; height: 20px;" type="checkbox"/>	6 <input style="width: 20px; height: 20px;" type="checkbox"/>
My partner does not have many friends or family members in this work location	1 <input style="width: 20px; height: 20px;" type="checkbox"/>	2 <input style="width: 20px; height: 20px;" type="checkbox"/>	3 <input style="width: 20px; height: 20px;" type="checkbox"/>	4 <input style="width: 20px; height: 20px;" type="checkbox"/>	5 <input style="width: 20px; height: 20px;" type="checkbox"/>	6 <input style="width: 20px; height: 20px;" type="checkbox"/>
There are good employment opportunities for my partner in this work location	1 <input style="width: 20px; height: 20px;" type="checkbox"/>	2 <input style="width: 20px; height: 20px;" type="checkbox"/>	3 <input style="width: 20px; height: 20px;" type="checkbox"/>	4 <input style="width: 20px; height: 20px;" type="checkbox"/>	5 <input style="width: 20px; height: 20px;" type="checkbox"/>	6 <input style="width: 20px; height: 20px;" type="checkbox"/>
The choice of schools for our children is adequate in this work location	1 <input style="width: 20px; height: 20px;" type="checkbox"/>	2 <input style="width: 20px; height: 20px;" type="checkbox"/>	3 <input style="width: 20px; height: 20px;" type="checkbox"/>	4 <input style="width: 20px; height: 20px;" type="checkbox"/>	5 <input style="width: 20px; height: 20px;" type="checkbox"/>	6 <input style="width: 20px; height: 20px;" type="checkbox"/>

33. Are you subject to restrictions on where you practise?

1 Yes—I am required to work in an Area of Need
 2 Yes—I am required to work in a District of Workforce Shortage
 3 No—Go to question 35

34. Please indicate the reason/s for these restrictions.

- I hold a Permanent Resident Visa
- I hold a Temporary Resident Visa
- I am undertaking a return of service period for a Medical Rural Bonded Scholarship or Bonded Medical Place
- I am undertaking a compulsory rural placement as part of my training
- Other

G About your family circumstances

35. Are you currently living with a partner or spouse?

1 Yes 2 No

36. What is the employment status of your partner/spouse?

- 1 Not in the labour force (e.g. caring for dependents, studying)
- 2 Currently seeking work
- 3 Full-time employment
- 4 Part-time employment
- 5 Not Applicable

37. How many dependent children do you have? (If none, write 0)

38. What is the age in years of each dependent child?

Not Applicable (Tick box)

Child 1.....

Child 2.....

Child 3.....

Child 4.....

Child 5.....

Child 6.....

39. Which of the following forms of childcare are you using for your children of pre-school age? (Please tick all that apply)

Relatives or friends

Nannies

Childcare at work (i.e. provided by an employer)

Other day care (childcare centre, family day care, kindergarten etc.)

Not Applicable

40. Please indicate the degree to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am restricted in my employment and/or the time and hours I work due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is restricted in his/her employment and/or the time and hours worked due to a lack of available childcare	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My partner is overqualified for his/her current job due to the limited availability of suitable jobs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

H About you

41. If you completed your medical degree in Australia, were you an international student (i.e. were you a citizen of a country outside of Australia and New Zealand)?

1 Yes

2 No

3 Not Applicable

42. If you did your degree at a medical school outside of Australia, have you completed the AMC Certificate examination?

1 Yes

2 No

3 Not Applicable

43. If you completed your medical degree outside of Australia:

What year did you first arrive in Australia?

In what year were you first registered to work as a doctor in Australia?

Not Applicable (Tick box)

44. Do you have medical qualifications from overseas which are NOT recognised in Australia?

1 Yes

2 No

3 Unsure

HOSPITAL DOCTOR NOT ENROLLED IN A SPECIALTY TRAINING PROGRAM

45. Please indicate all medical qualifications that you have obtained in Australia.

	Number of qualifications (e.g. 1, 2 etc)	Name of degree (e.g. MBBS, FRACP)
Undergraduate degree	<input type="text"/>	<input type="text"/>
Graduate entry medical degree	<input type="text"/>	<input type="text"/>
Masters degree	<input type="text"/>	<input type="text"/>
PhD	<input type="text"/>	<input type="text"/>
Postgraduate diploma/certificate	<input type="text"/>	<input type="text"/>
Fellowship of college	<input type="text"/>	<input type="text"/>
Others	<input type="text"/>	<input type="text"/>
I have qualifications from overseas which are recognised in Australia (Tick box) <input type="checkbox"/>		

46. What is your residency status? (Tick one box)

¹ Australian citizen
² Permanent resident
³ Temporary resident

47. What type of medical registration do you have? (Please tick all that apply)

General registration
 Specialist registration
 Provisional registration
 Limited registration
 Non-practising registration

48. In general, would you say your health is: (Tick one box)

¹ Excellent
² Very good
³ Good
⁴ Fair
⁵ Poor

49. All things considered, how satisfied are you with your life in general? (Tick one box)

	Completely Dissatisfied										Completely Satisfied
	1	2	3	4	5	6	7	8	9	10	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

50. The personal life events listed below can have an important influence on a person's work-life balance.

For each statement below, please indicate 'YES' or 'NO' as to whether you experienced the event during the past 12 months. For each statement you answer 'YES', please indicate how long ago the event occurred or commenced.

			If 'YES', please indicate how long ago it happened.			
			0 to 3 months ago	4 to 6 months ago	7 to 9 months ago	10 to 12 months ago
Serious personal injury or illness to self	No ¹ <input type="text"/>	Yes ² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Serious personal injury or illness to a close relative or family member	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Death of spouse or child	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Death of other close relative or family member (e.g. parent or sibling)	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Death of a close friend	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Victim of physical violence (e.g. assault)	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Victim of a property crime (e.g. theft, housebreaking)	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>
Named as defendant in a medical negligence claim	¹ <input type="text"/>	² <input type="text"/>	¹ <input type="text"/>	² <input type="text"/>	³ <input type="text"/>	⁴ <input type="text"/>

51. We would like your email address to assist us in contacting you in future Waves. If we are unable to contact you by mail when distributing the MABEL survey, we will contact you by email instead. This information will be used only for this purpose. If possible, please provide a non-work email address to facilitate contact in the event you change jobs.

Email address:

52. Thank you for completing the survey. Please provide any further comments below.

Dotted lines for providing comments.

In case of loss of included reply-paid envelope, please forward survey to:
Melbourne Institute of Applied Economic and Social Research – MABEL Survey
Reply Paid 84574
UNIVERSITY OF MELBOURNE VIC 3010