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# MABEL

Medicine in Australia: Balancing Employment and Life  
2014

## Doctor Enrolled in a Specialty Training Program (Specialist Registrar)

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**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?

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

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

- <sup>1</sup>  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.  
<sup>2</sup>  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 specify occupation:

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

- <sup>1</sup>  Yes – Please go to Section G and complete the final two sections of the survey  
<sup>2</sup>  Unsure – Please go to Section G and complete the final two sections of the survey  
<sup>3</sup>  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

## C About the places where you work

8. 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) . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Private hospital . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Private medical practitioner's rooms or surgery . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.) . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Tertiary education institution . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
TOTAL HOURS WORKED . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

9. Approximately how many hours per week do you work as a hospital locum? (If zero, write 0) . . . . .

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

Hospital name . . . . .

Postcode . . . . .

11. How long have you worked at this hospital?

No. of years . . . . .

No. of months . . . . .

## D About your workload

12. 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 8) . . . . .    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

13. In relation to education activities, are you involved in any of the following teaching or supervisory activities, including formal and informal teaching and supervision? (Please tick all that apply)

- <sup>1</sup>  Teaching or supervising medical students  
<sup>2</sup>  Teaching or supervising interns and pre-vocational trainees  
<sup>3</sup>  No – I am not involved in any teaching or supervision

14. In relation to non-clinical activities OUTSIDE your usual place of work, are you currently involved in any of the following activities? (Please tick all that apply)

- Elected office bearer (e.g. president, treasurer) or board member of a national or state-level professional organisation (e.g. the Australian Medical Association, the College of Physicians).  
 Committee member in a national or state-level professional organisation, advisory group and/or steering group.  
 I am not currently involved in any of the activities listed above.

15. 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) . . . . .

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

- <sup>1</sup>  Yes  
<sup>2</sup>  No— Go to question 19

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

How many HOURS were you rostered or listed for on-call? . . . . .    hrs/wk  
 How many HOURS were actually spent in direct patient care? . . . . .    hrs/wk  
 How many TIMES were you actually called out? . . . . .    times/wk

18. 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) . . . . .

19. 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.

20. 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) \$ . . . . .			
After tax (net earnings) \$ . . . . .			

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

<sup>1</sup>  Yes  
<sup>2</sup>  No

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

23. 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) . . . . .

24. 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) . . . . .

25. How much personal gross income, in addition to income from your medical work, do you receive from other sources each year? (e.g. bank interest, dividend income, rental income and profit from business interests) (If none, write 0)

\$ . . . . .

26. 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 20. 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) \$ . . . . .			
After tax (net household income) \$ . . . . .			

## F About your geographic location

27. Where is your main place of work?

Town/Suburb . . . . .

Postcode . . . . .

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

No. of years . . . . .

No. of months . . . . .

29. Where do you live?

Town/Suburb . . . . .

Postcode . . . . .

30. 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 type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is easy to pursue my hobbies and leisure interests in my current work location	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 does not have many friends or family members in this work location	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 are good employment opportunities for my partner in this work location	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 choice of schools for our children is adequate in this work location	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

31. 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 33

32. 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

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

1  Yes  
 2  No

34. 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

35. How many dependent children do you have? (If none, write 0 and skip the next two questions) . . . . .

36. 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. . . . .

37. 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

38. 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

39. 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

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

- 1  Yes  
 2  No  
 3  Not Applicable

41. 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) .....

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

- 1  Yes  
 2  No  
 3  Unsure

43. Please indicate all NEW medical qualifications that you have completed in the last 12 months.

	Number of qualifications	Names of qualifications
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"/>

44. Do you have a research-based degree from medical school in addition to your primary medical qualification? For example: BSc(Med)(Hons), BSc(Hons), MBBS(Hons).

- 1  Yes  
 2  No

45. Please indicate how many other health and non-health related qualifications you have received in Australia in the last 12 months.

No. of qualifications .....

46. Which specialty training program are you enrolled in?

- 1  Addiction medicine
- 2  Anaesthesia
- 3  Dermatology
- 4  Emergency medicine
- 5  Intensive care medicine
- 6  Medical administration
- 7  Obstetrics and gynaecology
- 8  Occupational and environmental medicine
- 9  Ophthalmology
- 10  Paediatrics and child health
- 11  Pain medicine
- 12  Palliative medicine
- 13  Pathology
- 14  Physician
- 15  Psychiatry
- 16  Public health medicine
- 17  Radiation oncology
- 18  Radiology
- 19  Rehabilitation medicine
- 20  Sexual health medicine
- 21  Sport and exercise medicine
- 22  Surgery

47. In what year do you expect to complete the program and become a qualified specialist? . . . . .

48. Which specialist training courses have you applied for in the past? (Please tick all that apply)

- 1  None, not applicable
- 2  Addiction medicine
- 3  Anaesthesia
- 4  Dermatology
- 5  Emergency medicine
- 6  General Practice
- 7  Intensive care medicine
- 8  Medical administration
- 9  Obstetrics and gynaecology
- 10  Occupational and environmental medicine
- 11  Ophthalmology
- 12  Paediatrics and child health
- 13  Pain medicine
- 14  Palliative medicine
- 15  Pathology
- 16  Physician
- 17  Psychiatry
- 18  Public health medicine
- 19  Radiation oncology
- 20  Radiology
- 21  Rehabilitation medicine
- 22  Sexual health medicine
- 23  Sport and exercise medicine
- 24  Surgery



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

- Australian citizen
- Permanent resident
- Temporary resident

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

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

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

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

53. This question asks about everyday risk-taking in relation to different types of activities.

How likely are you to engage in each of the following activities (with a score of 1 being 'very unlikely' and 5 being 'very likely')?

	Very unlikely 1	2	3	4	Very likely 5
Financial risks (e.g. investments with an uncertain outcome)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Career and professional risks (e.g. publicly challenging your professional colleagues)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Clinical risks (e.g. recommending a treatment which is new to your usual practice or is controversial)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

54. 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.

	No	Yes	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	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Serious personal injury or illness to a close relative or family member	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Death of spouse or child	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Death of other close relative or family member (e.g. parent or sibling)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Death of a close friend	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Victim of physical violence (e.g. assault)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Victim of a property crime (e.g. theft, housebreaking)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Named as defendant in a medical negligence claim	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

55. 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:





