

Mabel username id:

MABEL

Medicine in Australia: Balancing Employment and Life
2014

Specialist

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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?

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 specify occupation:

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 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"/> |

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"/> |
| Running my practice is stressful most of the time | 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 my career | 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 (including day time and after hours)?

- 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 |
| Laboratory or radiology facility | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk |
| Community health centre | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk |
| Government department, agency or defence forces | <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. Do you work in private practice?

- 1 Yes, in a public or private hospital and private consulting rooms
- 2 Yes, in a public or private hospital only—Go to question 13
- 3 No—Go to question 14

10. What is the total number of specialists who work in your current, main private practice? (Include yourself if applicable) (If none, write 0)

| | Full-time | Part-time |
|--------------------------|---|---|
| No. of males | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| No. of females | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |

11. How many other health workers or professionals are employed in your current, main private practice? (If none, write 0)

| | |
|--|---|
| No. of nurses | <input type="text"/> <input type="text"/> |
| No. of allied health professionals | <input type="text"/> <input type="text"/> |
| No. of administrative staff | <input type="text"/> <input type="text"/> |
| No. of other staff | <input type="text"/> <input type="text"/> |

SPECIALIST

12. Is your current, main private practice co-located with other specialist practices?

- 1 Yes
 2 No

13. What is your business relationship with your current main practice?

- 1 Principal or partner
 2 Associate
 3 Salaried employee (e.g. receive fixed annual salary & benefits with tax deducted)
 4 Contracted employee (e.g. receive fixed payment per session or a % of billings before tax)
 5 Locum
 6 Other (please specify)

14. How many hours a week do you work as a hospital locum? (If zero, write 0)

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

Hospital name
 Postcode

16. How are you paid for this hospital work?

- 1 Fee-for-service/bill patients directly
 2 Fixed payment per session or hour
 3 Salary—no rights to private practice
 4 Salary with rights to private practice
 5 Other, please specify

D

About your workload

17. 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: with or without a medical student present) hrs/wk
 Indirect patient care (medical notes, reports, phone calls, meeting patients' families). hrs/wk
 Education activities (teaching, research, continuing medical education) hrs/wk
 Management and administration hrs/wk
 Other hrs/wk

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

- Teaching or supervising medical students
 Teaching or supervising interns and pre-vocational trainees
 Teaching or supervising specialist registrars
 No, I am not involved in any teaching or supervision

19. 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.

SPECIALIST

20. 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)

| | |
|---|--|
| Total number of patients seen in private consulting rooms. | |
| Total number of public patients seen in a public hospital. | |
| Total number of private patients seen in a public hospital | |
| Total number of private patients seen in a private hospital | |

21. How long does a new PRIVATE patient typically have to wait for an appointment?

| | | |
|---|--------------------------|-------|
| No. of days | | days |
| No. of weeks | | weeks |
| Not taking new patients at present (Tick box) | <input type="checkbox"/> | |
| Not Applicable (Tick box) | <input type="checkbox"/> | |

22. How long does a standard private consultation last?

| | | |
|---|--------------------------|---------|
| New patient/ Initial consultation | | minutes |
| Subsequent consultations | | minutes |
| Not Applicable (Tick box) | <input type="checkbox"/> | |

23. Approximately what percentage of patients do you bulk bill/charge no co-payment?

| | | |
|-------------------------------------|--------------------------|---|
| Per cent | | % |
| Not Applicable (Tick box) | <input type="checkbox"/> | |

24. What is your current fee for a standard private consultation? (Include Medicare fee and patient co-payment if applicable. Please write dollar amount; write 0 if you bulk bill 100% of your patients)

| | | |
|---|----|--------------------------|
| New patient/initial consultation. | \$ | |
| Subsequent consultations | \$ | |
| Not Applicable (Tick box) | | <input type="checkbox"/> |

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

¹ Yes

² No— Go to question 29

26. What are your on-call ratios for public and private sector work?
(For example, 5 weeknights per fortnight equals 1 in 2)

| | Public sector work | Private sector work |
|-------------------------------------|--------------------------|---------------------|
| 1 weeknight in | | |
| 1 weekend in | | |
| Not Applicable (Tick box) | <input type="checkbox"/> | |

27. In your last usual week at work, how many TIMES were you actually called out? (If none, write 0)

| | Public sector work | Private sector work |
|--------------------------------------|--------------------------|---------------------|
| Weeknights: times per week | | |
| Weekend: times per weekend | | |
| Not Applicable (Tick box) | <input type="checkbox"/> | |

28. If your on-call arrangements do not fit the above descriptions, please elaborate below:

29. Opportunities for continuing medical education and professional development are: (Tick one box)

¹ Very limited

² Average

³ Very good

30. 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.

31. 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.) This should be your personal earnings rather than total practice earnings. Please write in ONE COLUMN where you have the most accurate information and can best remember.

| | Annual | OR | Fortnightly |
|--|--------|----|-------------|
| Before tax (gross earnings) \$ | | OR | |
| After tax (net earnings) \$ | | | |

32. 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)?

¹ Yes

² No

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

34. 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)

35. What is the total level of financial debt that you currently have from owning your practice or premises? (If zero, write 0)
- \$
- Don't Know (Tick box)
- Not Applicable (Tick box)

36. What is the status of your private practice for tax purposes?

¹ Sole trader

² Partnership

³ Company

⁴ Trust

⁵ Don't Know

⁶ Not Applicable

37. 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)
- \$

38. 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)

39. 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 31. 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) \$ | | OR | |
| After tax (net household income) \$ | | | |

F About your geographic location

40. In how many locations do you practise?

41. Where is your main place of work?

Town/Suburb

Postcode

42. Where do you live?

Town/Suburb

Postcode

43. 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"/> |

44. 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 46

45. 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
 Other
 Not Applicable

46. Do you travel to provide services/clinics in other geographic areas?

- 1 Yes
 2 No—Go to question 60

47. Where are you providing these services? Please list up to three locations below.

| | Town/Suburb | Postcode |
|------------------|----------------------|----------------------|
| Location 1 | <input type="text"/> | <input type="text"/> |
| Location 2 | <input type="text"/> | <input type="text"/> |
| Location 3 | <input type="text"/> | <input type="text"/> |

48. Do you provide any of these services in a **non-metropolitan** location (i.e. a rural, regional or remote location)?

- 1 Yes
 2 No—Go to question 60

49. At which non-metropolitan location did you spend the most time in the last 12 months? (Tick one box)

- 1 Location 1
 2 Location 2
 3 Location 3

50. How often did you visit this location in the last year?

No. of visits

51. In what year did you start providing services to this location?

52. How long does it take to travel to this location from your normal place of residence?

- 1 Less than 1 hour
- 2 From 1 to 3 hours
- 3 4 or more hours

53. Are you paid a salary/fixed payment for your services at this location?

- 1 Yes
- 2 No

54. What main approach do you take to patient co-payments (gap payments) for your services at this location?

- 1 Mostly I charge patients a gap payment
- 2 Mostly bulk bill patients under Medicare
- 3 Mostly no patient charges are applied and no Medicare claim is made

55. Do you currently receive any reimbursement or subsidy for your services to this location (e.g. for travel costs)?

- 1 Yes, from the Commonwealth, e.g. Rural Health Outreach Fund
- 2 Yes, from another source
- 3 No

56. Did you lead the establishment of the service to this location?

- 1 Yes
- 2 No

57. Are you required to provide services to this location as part of your employment conditions at your main place of work?

- 1 Yes
- 2 No

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

| I provide this service in order to: | Strongly Agree | Agree | Neither agree nor disagree | Disagree | Strongly Disagree |
|--|----------------------------|----------------------------|-------------------------------|----------------------------|----------------------------|
| Grow my practice | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| Provide healthcare to disadvantaged people | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| Maintain a personal connection to a region | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| Provide complex healthcare in challenging situations | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| Provide support for local rural health staff | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

59. For how long do you plan to continue providing services to this location?

- 1 For less than five years – Go to question 63
- 2 For five years or more – Go to question 63

60. Are you considering travelling to provide services in a non-metropolitan (i.e. rural, regional or remote) location in the next five years?

- 1 Yes
- 2 No

61. Have you previously travelled to provide services in a non-metropolitan location?

- 1 Yes
- 2 No – Go to question 63

62. Have you previously received Commonwealth funding, e.g. through MSOAP, for providing services to a non-metropolitan location?

- 1 Yes
- 2 No

G About your family circumstances

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

- 1 Yes
- 2 No

64. 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

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

66. 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.

67. 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

68. 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

69. 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

70. 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)

SPECIALIST

71. 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 style="width: 100%;" type="text"/> |
| PhD | <input type="text"/> | <input style="width: 100%;" type="text"/> |
| Postgraduate diploma/certificate | <input type="text"/> | <input style="width: 100%;" type="text"/> |
| Fellowship of college | <input type="text"/> | <input style="width: 100%;" type="text"/> |

72. 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

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

No. of qualifications

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

- ¹ Yes
² No
³ Unsure

75. What is the main specialty in which you practise? (If you practise in a second specialty, please specify)

| | Main specialty in which you practise (Where you are qualified & recognised under the Health Insurance Act) | Second specialty in which you practise |
|---|--|--|
| PHYSICIAN: | | |
| Cardiology | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| Clinical genetics | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| Clinical pharmacology | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| Endocrinology | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Gastroenterology and hepatology | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| General medicine | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| Geriatric medicine | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> |
| Haematology | 8 <input type="checkbox"/> | 8 <input type="checkbox"/> |
| Immunology and allergy | 9 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| Infectious diseases | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| Medical oncology | 11 <input type="checkbox"/> | 11 <input type="checkbox"/> |
| Neurology | 12 <input type="checkbox"/> | 12 <input type="checkbox"/> |
| Nuclear medicine | 13 <input type="checkbox"/> | 13 <input type="checkbox"/> |
| Nephrology | 14 <input type="checkbox"/> | 14 <input type="checkbox"/> |
| Rheumatology | 15 <input type="checkbox"/> | 15 <input type="checkbox"/> |
| Respiratory and sleep medicine | 16 <input type="checkbox"/> | 16 <input type="checkbox"/> |
| SURGERY: | | |
| General surgery | 17 <input type="checkbox"/> | 17 <input type="checkbox"/> |
| Cardiothoracic surgery | 18 <input type="checkbox"/> | 18 <input type="checkbox"/> |
| Oral and maxillofacial surgery | 19 <input type="checkbox"/> | 19 <input type="checkbox"/> |
| Orthopaedic surgery | 20 <input type="checkbox"/> | 20 <input type="checkbox"/> |
| Otolaryngology | 21 <input type="checkbox"/> | 21 <input type="checkbox"/> |
| Paediatric surgery | 22 <input type="checkbox"/> | 22 <input type="checkbox"/> |
| Plastic surgery | 23 <input type="checkbox"/> | 23 <input type="checkbox"/> |
| Urology | 24 <input type="checkbox"/> | 24 <input type="checkbox"/> |
| Neurosurgery | 25 <input type="checkbox"/> | 25 <input type="checkbox"/> |
| Vascular surgery | 26 <input type="checkbox"/> | 26 <input type="checkbox"/> |
| OTHER SPECIALTIES: | | |
| Addiction medicine | 27 <input type="checkbox"/> | 27 <input type="checkbox"/> |
| Anaesthesia | 28 <input type="checkbox"/> | 28 <input type="checkbox"/> |
| Dermatology | 29 <input type="checkbox"/> | 29 <input type="checkbox"/> |

| | Main specialty in which you practise (Where you are qualified & recognised under the Health Insurance Act) | Second specialty in which you practise |
|--|---|---|
| Emergency medicine | 30 <input type="checkbox"/> | 30 <input type="checkbox"/> |
| Intensive care medicine | 31 <input type="checkbox"/> | 31 <input type="checkbox"/> |
| Medical administration | 32 <input type="checkbox"/> | 32 <input type="checkbox"/> |
| Obstetrics and gynaecology | 33 <input type="checkbox"/> | 33 <input type="checkbox"/> |
| Occupational and environmental medicine | 34 <input type="checkbox"/> | 34 <input type="checkbox"/> |
| Ophthalmology | 35 <input type="checkbox"/> | 35 <input type="checkbox"/> |
| Paediatrics and child health | 36 <input type="checkbox"/> | 36 <input type="checkbox"/> |
| Pain medicine | 37 <input type="checkbox"/> | 37 <input type="checkbox"/> |
| Palliative medicine | 38 <input type="checkbox"/> | 38 <input type="checkbox"/> |
| Pathology | 39 <input type="checkbox"/> | 39 <input type="checkbox"/> |
| Psychiatry | 40 <input type="checkbox"/> | 40 <input type="checkbox"/> |
| Public health medicine | 41 <input type="checkbox"/> | 41 <input type="checkbox"/> |
| Radiology | 42 <input type="checkbox"/> | 42 <input type="checkbox"/> |
| Radiation oncology | 43 <input type="checkbox"/> | 43 <input type="checkbox"/> |
| Rehabilitation medicine | 44 <input type="checkbox"/> | 44 <input type="checkbox"/> |
| Sexual health medicine | 45 <input type="checkbox"/> | 45 <input type="checkbox"/> |
| Sport and exercise medicine | 46 <input type="checkbox"/> | 46 <input type="checkbox"/> |
| OTHER SPECIALTY not specified above | 47 <input type="checkbox"/> | 47 <input type="checkbox"/> |

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

- 1 Australian citizen
- 2 Permanent resident
- 3 Temporary resident

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

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

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

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

79. 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 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> | 7 <input type="checkbox"/> | 8 <input type="checkbox"/> | 9 <input type="checkbox"/> | 10 <input type="checkbox"/> |

80. 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 | 5 | Very likely |
|--|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------|
| Financial risks (e.g. investments with an uncertain outcome) | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5 |
| Career and professional risks (e.g. publicly challenging your professional colleagues) | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5 |
| Clinical risks (e.g. recommending a treatment which is new to your usual practice or is controversial) | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5 |

