

Mabel username id:

MABEL

Medicine in Australia: Balancing Employment and Life

2018

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 three sections of the survey*

² Unsure – *Please go to Section G and complete the final three 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"/>
I can take time off at short notice, for example if one of my children is ill or for a home maintenance emergency	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"/>
My colleagues understand the need for work–life balance	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 cannot work my preferred hours due to a lack of jobs offering those hours	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. Imagine you would like to **REDUCE** your hours of work. How achievable is this? (Tick one box)

- 1 This could be achieved easily within my current job
- 2 This could be achieved with some difficulty in my current job
- 3 I would have to change jobs, but there are suitable opportunities in my local area
- 4 I would have to change jobs, and such jobs are scarce
- 5 This would be impossible
- 6 Don't know

8. This question asks about any workplace aggression directed towards you in the past 12 months whilst you were working in medicine (i.e. any circumstance or location in which you performed your role as a medical practitioner), including:

- Verbal or written abuse, threats, intimidation or harassment – such as ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation;
- Physical threats, intimidation, harassment or violence – such as a raised hand or object, unwanted touching, damage to property and sexual or other physical assault.

For each potential source of aggression, please tick the box that most closely matches how often you experienced that type of aggression in the past 12 months.

	Frequently (once or more a week)	Often (a few times each week)	Occasionally (a few times each 6 mths)	Infrequently (a few times in 12 mths)	Not at all
A. Aggression from patients:					
Verbal or written abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physical threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
B. Aggression from relatives or carers:					
Verbal or written abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physical threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
C. Aggression from any workplace supervisor or co-worker:					
Verbal or written abuse, threats, intimidation or harassment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physical threats, intimidation, harassment or violence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

9. The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work? Please select the response that best corresponds with your experience over the last six months.

	Never	Now and then	Monthly	Weekly	Daily
Someone withholding information which affects your performance	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Repeated reminders of your errors or mistakes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Persistent criticism of your work and effort	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Spreading of gossip and rumours about you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Being shouted at or being the target of spontaneous anger (or rage)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Being ignored or excluded (being 'sent to Coventry')	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Being ignored or facing a hostile reaction when you approach	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Practical jokes carried out by people you don't get on with	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

C About the places where you work

10. 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"/> hrs/wk
Private hospital	<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"/> hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Laboratory or radiology facility	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Community health centre	<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"/> hrs/wk
Tertiary education institution	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
TOTAL HOURS WORKED.	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

11. 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 14
- 3 No—Go to question 16

12. 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"/>

13. 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"/>

14. What is your business relationship with your current main practice? (Tick one box)

- 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)

15. When did you start working at this practice?

Month

Year

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

Hospital name

Postcode

17. 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

18. 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 10). 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

19. 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 other pre-vocational trainees
- Teaching or supervising specialist registrars
- No, I am not involved in any teaching or supervision

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)
 Not Applicable (Tick box)

22. How long does a standard private consultation last?

New patient/ Initial consultation minutes
 Subsequent consultations minutes
 Not Applicable (Tick box)

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

Per cent. %
 Not Applicable (Tick box)

24. Including the Medicare rebate and patient co-payment where applicable, what is your TOTAL current fee for a standard private consultation? (Please write dollar amount)

New patient/initial consultation \$
 Most-used item number for initial consultation
 Subsequent consultations \$
 Most-used item number for subsequent consultations
 Not Applicable (Tick box)

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	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1 weekend in	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Not Applicable (Tick box)	<input type="checkbox"/>	<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	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Weekend: times per weekend	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Not Applicable (Tick box)	<input type="checkbox"/>	<input type="checkbox"/>

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

29. 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

30. In your last usual week at work, did you use digital health technologies/solutions for the following activities?

	Yes	No, but would like to	No, and don't need to	Not applicable
Sending/receiving referrals from other health practitioners	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Communicating/messaging with other clinicians about patient care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Viewing pathology or diagnostic imaging results	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Ordering pathology tests or diagnostic imaging	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Storing advanced care planning documents	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Completing/viewing event summaries (e.g. discharge summaries/specialist reports)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Writing prescriptions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Viewing medicines information	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Viewing immunisation information	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Viewing patient information entered by other health professionals outside my main place of work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Entering/updating patient information during or after consultations or procedures	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Clinical audit and research	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Using digital decision support tools to help inform clinical decisions (e.g. clinical dashboards; automated alerts, warnings and reminders; algorithms; electronic clinical guidelines and pathways)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

31. To what extent do you agree or disagree with the following statements about the use of digital health technologies/solutions?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
They improve patient health outcomes and satisfaction (e.g. fewer errors)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
They are too difficult and time consuming to use	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Colleagues and support staff already extensively use digital health technologies	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
There is insufficient support (e.g. training, on-site IT support, funding)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
They improve care processes (e.g. improve care co-ordination, continuity of care, reduce duplication)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
My patients are concerned about data privacy and security	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Easily sharing information with others involved in patient care from different organisations is very important	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
New IT systems are often incompatible with existing IT systems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
I have no concerns about data privacy or security	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
They save time for me and my patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
The quality and relevance of stored information is poor	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
I receive support and advice on IT security from my main place of work (e.g. on password protection/ encryption, staff training, firewalls, back-ups)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
My main place of work has provided guidance to me on what to do if a cyber security incident is detected	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

32. At your main work location, do you currently use an electronic health record? In other words, do you maintain information about your patients' health and healthcare in a computer-readable format?

- 1 Yes
- 2 No

33. How often do you use real-time video consultations for clinical services?

- 1 Not Applicable
- 2 Applicable to my practice but have never used them
- 3 Less than once per month
- 4 1–3 times a month
- 5 Every week
- 6 Every day

34. How would you describe the video consultations you were involved with during the last usual month? (Tick all that apply)

- 1 The patient was with me and we talked to a specialist elsewhere
- 2 The patient was with me and we talked to another health professional elsewhere
- 3 I was alone and talked to a patient who was elsewhere with a specialist
- 4 I was alone and talked to a patient who was elsewhere with another health professional
- 5 I was alone and talked to a patient elsewhere who was also alone
- 6 Other
- 7 Not Applicable

35. Were any of these video consultations provided to patients in a rural area?

- 1 Yes
- 2 No
- 3 Not Applicable

36. What is the main rural area where you provided these video consultations?

Town

State

Postcode

Not Applicable (Tick box)

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.

37. 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) \$			
After tax (net earnings) \$			

38. 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)?

- 1 Yes
- 2 No

39. How would you describe the ownership structure of the main practice in which you work?

- 1 Sole trader
- 2 Partnership
- 3 Company/Corporation
- 4 Trust
- 5 Don’t Know
- 6 Not Applicable

40. 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)

\$

41. 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 37. 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

42. In how many locations do you practise?

43. Where is your main place of work?

Town/Suburb

Postcode

44. Where do you live?

Town/Suburb

Postcode

45. 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"/>

46. 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 48

47. 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

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

1 Yes

2 No – Go to question 50

49. 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"/>

G About your family circumstances

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

- ¹ Yes
² No

51. What is the employment status of your partner/spouse? (Tick one box)

- 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

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

53. 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.

54. 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

55. 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"/>

H About you

56. Did you participate in rural placements as part of your basic medical degree?

- ¹ Yes
² No—Go to question 58

SPECIALIST

57. Where did you undertake these placements? If applicable please list up to three locations and the TOTAL time spent in each.

	Town	State/Territory (or country if not Australia)	
Location 1 ...	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	Total time spent in location 1 <input type="checkbox"/> < 12 weeks 2 <input type="checkbox"/> From 3 to 12 months 3 <input type="checkbox"/> More than 1 university year
Location 2 ...	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	1 <input type="checkbox"/> < 12 weeks 2 <input type="checkbox"/> From 3 to 12 months 3 <input type="checkbox"/> More than 1 university year
Location 3 ...	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	1 <input type="checkbox"/> < 12 weeks 2 <input type="checkbox"/> From 3 to 12 months 3 <input type="checkbox"/> More than 1 university year

58. During the first 10 years after completing your basic medical degree, how many years (0 to 10) did you spend training or working in a rural area? (If none, write 0 and skip the next question)

59. Where did you do this rural training or work? If applicable, please list up to three locations where you had the longest rural exposure.

	Town	State/Territory (or country if not Australia)
Location 1	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Location 2	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Location 3	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

60. 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

61. If you completed your medical degree outside 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)

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

	Number of qualifications	Names of qualifications
Masters degree	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>
PhD	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>
Postgraduate diploma/certificate	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>
Fellowship of college	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 100%;" type="text"/>

63. 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

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

No. of qualifications.

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

- 1 Yes
 2 No
 3 Unsure

66. 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"/>
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"/>

67. Since you graduated, how many years and/or months have you spent NOT practising as a doctor? (Include time to bring up a family, time in non-medical jobs or study; exclude holidays and medically-related study leave) (If none, write 0)

No. of years

No. of months

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

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

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

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

I About your health and wellbeing

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

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

71. 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	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"/>

72. Please respond to each of the following statements using a 1 to 7 point scale, where 1 means 'Strongly disagree' and 7 means 'Strongly agree'.

	Strongly disagree	1	2	3	4	5	6	7	Strongly agree					
You can learn new things but you can't really change your basic intelligence	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"/>
No matter who you are, you can significantly change your intelligence level	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"/>

73. 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		If 'YES', please indicate how long ago it happened.			
	1	2	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious personal injury or illness to a close relative or family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of spouse or child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of other close relative or family member (e.g. parent or sibling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a close friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Victim of physical violence (e.g. assault)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Victim of a property crime (e.g. theft, housebreaking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the subject of a complaint, concern or notification to a health regulation body (e.g. AHPRA, NSW Health Professional Councils Authority, QLD Health Ombudsman)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had restrictions (e.g. undertakings, conditions, suspensions or cancellations) placed on your medical registration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Named as defendant in a medical negligence claim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74. This and the following five questions relate to how you have been feeling during the PAST 30 DAYS. For each question below please select the option which best describes how often you experienced this feeling. (Tick one box per row)

During the past 30 days, about how often did you feel:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Nervous	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Hopeless	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Restless or fidgety	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
So depressed that nothing could cheer you up	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
That everything was an effort	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Worthless	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

75. Considering your responses in the previous question all together, during the past 30 days did you have these feelings more often than usual, about the same as usual, or less often than usual? (If you *never* experience any of the feelings listed above select the 'Never' response below and go to question 78.)

A lot more often than usual	Somewhat more often than usual	A little more often than usual	About the same as usual	A little less often than usual	Somewhat less often than usual	A lot less often than usual	Never - Go to Q78
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"/>

76. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

No. of days (If none, write 0)

77. During the past 30 days, how often have physical health problems been the main cause of these feelings?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

