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MABEL

Medicine in Australia: Balancing Employment and Life
2010

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

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MABEL has been endorsed by:

Australasian Society of Career Medical Officers	Australasian College for Emergency Medicine
Confederation of Postgraduate Medical Education Councils	Australasian College of Sports Physicians
Postgraduate Medical Council of Victoria	Joint Faculty of Intensive Care Medicine
Postgraduate Medical Council of South Australia	Australian College of Rural and Remote Medicine
Postgraduate Medical Education Council of Queensland	Australian Society of Anaesthetists
Postgraduate Medical Institute of Tasmania	Australia and New Zealand Society of Palliative Medicine Inc
NSW Institute of Medical Education and Training	Australian and New Zealand Society for Geriatric Medicine
Australian General Practice Training	Australian Society of Plastic Surgeons
Australian General Practice Network	Australian and New Zealand Intensive Care Society
General Practice Registrars Australia	Internal Medicine Society of Australia and New Zealand
Australian Medical Council	Australian and New Zealand Society of Nephrology
Royal Australian College of General Practitioners	Australian Rheumatology Association
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Royal College of Pathologists of Australasia	Australian Private Hospital Association
Royal Australian and New Zealand College of Ophthalmologists	Australian Orthopaedic Association
Royal Australian and New Zealand College of Radiologists	Rural Doctors Association of Australia
Australia and New Zealand College of Anaesthetists	Rural Health Workforce Australia



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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

- Are you currently doing any clinical medical in Australia?
 - Yes – *If yes, please go to Section B below and complete the main survey*
 - No – *Continue*
- Are you permanently retired from all types of paid work?
 - 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.*
 - No – *Continue*
- Which of the following statements describe your current situation? (Tick all that apply)
 - Doing medical work in Australia that is non-clinical (e.g. medico-legal, teaching, research, committee work)
 - Maternity leave
 - Home duties/childcare
 - Enrolled as a student
 - Extended leave (e.g. sick leave, long service leave)
 - Working outside Australia in a clinical role
 - Working outside Australia in a non-clinical, but medical role
 - Working outside Australia in a non-medical role
 - Doing non-medical work in Australia. Please state job title:
- Do you intend to return to clinical medical work in Australia?
 - Yes – *Please go to Section G and complete the final two sections of the survey*
 - Unsure – *Please go to Section G and complete the final two sections of the survey*
 - 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

- Please indicate how satisfied or dissatisfied you are in 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"/>
The IT systems I use are very helpful in day-to-day practice	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"/>

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

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

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

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

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

Year

Don't know (Tick box)

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

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

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

Please specify:

Not Applicable (Tick box)

HOSPITAL DOCTOR NOT ENROLLED IN A SPECIALTY TRAINING PROGRAM

12. What is the likelihood that you will:

	Very Unlikely	Unlikely	Neutral	Likely	Very Likely
Leave direct patient care (primary or hospital) within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Leave medical work entirely within FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Reduce your clinical workload in the next FIVE YEARS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

13. This and the following question ask about any workplace aggression directed toward you in the last 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 each type of aggression in the past 12 months.

	Frequently (once or more each week)	Often (a few times each month)	Occasionally (a few times each 6 months)	Infrequently (a few times in 12 months)	Not at all
A. Aggression from patients					
<i>Verbal or written abuse, threats, intimidation or harassment</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical threats, intimidation, harassment or violence</i>	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 of patients					
<i>Verbal or written abuse, threats, intimidation or harassment</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical threats, intimidation, harassment or violence</i>	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 co-worker					
<i>Verbal or written abuse, threats, intimidation or harassment</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical threats, intimidation, harassment or violence</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
D. Aggression from any other person external to the workplace					
<i>Verbal or written abuse, threats, intimidation or harassment</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<i>Physical threats, intimidation, harassment or violence</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

14. Please indicate whether or not the following actions to prevent or minimise aggression have been implemented in your main workplace.

	Yes	No	Unsure	Not applicable
Policies, protocols and/or procedures for aggression prevention and management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Warning signs in reception and patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Alerts to high risk of aggression (e.g. on patient record)	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	
Restricting or withdrawing access to services for aggressive persons	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Incident reporting and follow-up	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Education and training (for self and other staff)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Duress alarms in consultation and treatment areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Clinician escape optimised in consultation / treatment rooms (e.g. seated closer to door than patient, two exits in rooms)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Optimised lighting, noise levels, comfort and waiting times in patient / public waiting areas	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Patient / public access restrictions (e.g. advisory signs, locked doors to treatment and storage areas)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Building security systems (e.g. burglar alarms, deadlocks, window bars, surveillance cameras, security personnel)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Safety and security measures for after hours or on-call work, or home visits (e.g. security escort to external areas at night, movement register, working in pairs, satellite phones)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Other (please specify)

C About the places where you work

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

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

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

Hospital name []

Postcode [][][][]

17. How long have you worked at this hospital?

No. of months [][]

No. of years [][]

18. What is your salaried position?

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

D About your workload

19. 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 15)	[][] 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

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) [][][]

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

- Yes
- No—Go to question 24

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

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

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

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

23. 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)

24. 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.

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

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

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

¹ Yes

² No

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

28. 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)

29. Do you (or your employer) regularly contribute to a superannuation scheme?

¹ Yes

² No

30. Please indicate the degree to which you agree with the following statement: "Given my current financial situation and prospects, I believe I will have enough to live on when I retire". (Tick one box)

¹ Strongly Disagree ² Disagree ³ Neutral ⁴ Agree ⁵ Strongly Agree

31. 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)

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

¹ Yes

² No

33. 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 25. Please write in ONE COLUMN ONLY, where you have the most accurate information or can best remember.

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

F About your geographic location

34. Where is your main place of work?

Town/Suburb

Postcode

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

No. of months

36. Where do you live?

Town/Suburb

Postcode

37. 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"/>

38. 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 40

39. 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

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

¹ Yes ² No

41. 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

42. Is your partner/spouse also a medical doctor?

¹ Yes
² No
³ Not Applicable

43. For how many years did your partner/spouse live in a rural area up until the age he/she left secondary school? (If none, write 0)

Don't know (Tick box)

Not Applicable (Tick box)

44. Please indicate the main rural area where your partner/spouse lived up until school leaving age.

Town
State
Don't know (Tick box)
Not Applicable (Tick box)

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

46. 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

47. 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

48. 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

49. Have you completed the AMC Certificate examination since the last time you did the MABEL survey?

- 1 Yes
 2 No
 3 Not Applicable

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

- 1 Yes
 2 No
 3 Unsure

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

- 1 Unchanged since I last completed the MABEL survey
 2 Australian citizen
 3 Permanent resident
 4 Temporary resident

52. What type of medical registration do you have?

- 1 Unchanged since I last completed the MABEL survey
 2 Full (unconditional) medical registration
 3 Conditional medical registration
 4 Other (please specify)

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

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

54. 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 <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"/> |

55. Please answer each of the following questions using a 1 to 7 point scale, where 1 means 'Strongly disagree' and 7 means 'Strongly agree'.

	Strongly disagree						Strongly agree
	1	2	3	4	5	6	7
I have little control over the things that happen to 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"/>	7 <input type="checkbox"/>
There is really no way I can solve some of the problems I have	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"/>
There is little I can do to change many of the important things in my life	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"/>
I often feel helpless in dealing with the problems of life	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"/>
Sometimes I feel that I'm being pushed around in life	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"/>
What happens to me in the future mostly depends on 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"/>	7 <input type="checkbox"/>
I can do just about anything I really set my mind on doing	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"/>

