

Mabel username id:

MABEL

Medicine in Australia: Balancing Employment and Life

2018

Doctor Enrolled in a Specialty Training Program

enquiries@mabel.org.au www.mabel.org.au Telephone: 03 8344 2600

Mailing address: Melbourne Institute of Applied Economic and Social Research – MABEL Survey
Reply Paid 84574, UNIVERSITY OF MELBOURNE VIC 3010

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	Rural Doctors Association of Australia
	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

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 job?	¹ <input type="checkbox"/>	² <input type="checkbox"/>	³ <input type="checkbox"/>	⁴ <input type="checkbox"/>	⁵ <input type="checkbox"/>	⁶ <input type="checkbox"/>

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

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The balance between my personal and professional commitments is about right	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have a poor support network of other doctors like me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is difficult to take time off when I want to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
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"/>
I have good support and supervision from qualified specialists	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
There is enough time for me to do personal study	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Research publications are important to progress my training	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The hours I work are unpredictable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I often undertake tasks that somebody less qualified could do	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
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 training program
- 2 This could be achieved with some difficulty in my current training program
- 3 I would have to change training program
- 4 This would be impossible
- 5 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
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. What is the main hospital in which you work (i.e. spend most time)?

Hospital name

Postcode

D About your workload

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

TOTAL HOURS WORKED PER WEEK (Should equal the TOTAL in question 10).	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Direct patient care (face-to-face, phone consultations, home visits).	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Indirect patient care (medical notes, reports, phone calls, meeting patients' families)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Education activities (academic research, continuing medical education)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Management and administration.	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

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

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

DOCTOR ENROLLED IN A SPECIALTY TRAINING PROGRAM

14. 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)

15. 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 18

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

How many HOURS were you rostered or listed for on-call? hrs/wk

How many HOURS were actually spent in direct patient care? hrs/wk

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

17. 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)

18. 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

19. 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"/>

20. 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"/>

21. 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

22. How often do you use real-time video consultants 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

23. 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

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

- 1 Yes
- 2 No
- 3 Not Applicable

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 current job/s (e.g. car, house, school fees)?

¹ Yes
² No

27. 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)

28. 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)

\$

29. 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

30. Where do you live?

Town/Suburb

Postcode

31. 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"/>

32. For how many years did you live in a rural area up until the age you left secondary school? (If none, write 0)

33. Please indicate the main rural area where you lived up until school leaving age.

Town

State

Not Applicable (Tick box)

34. 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 36

35. 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

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

¹ Yes

² No

37. 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

38. 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)

39. 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)

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

41. 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.

42. 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

43. Year of birth

44. Gender (Please tick one box)

1 Male

2 Female

3 Other (please specify)

45. In what year did you complete your basic medical degree?

46. In which country did you complete your basic medical degree?

A medical school in Australia

A medical school in the country specified:

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

1 Yes

2 No—Go to question 49

48. 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)	Total time spent in location
Location 1 ...	<input type="text"/>	<input 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 2 ...	<input type="text"/>	<input 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 type="text"/>	<input 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

49. 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)

50. 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 type="text"/>	<input type="text"/>
Location 2	<input type="text"/>	<input type="text"/>
Location 3	<input type="text"/>	<input type="text"/>

51. In which medical school in Australia did you complete your basic medical degree?

- | | |
|---|---|
| <p>¹ <input type="checkbox"/> Not Applicable</p> <p>³ <input type="checkbox"/> University of Adelaide</p> <p>⁵ <input type="checkbox"/> Australian National University</p> <p>⁷ <input type="checkbox"/> Bond University</p> <p>⁹ <input type="checkbox"/> Deakin University</p> <p>¹¹ <input type="checkbox"/> Flinders University</p> <p>¹³ <input type="checkbox"/> Griffith University</p> <p>¹⁵ <input type="checkbox"/> James Cook University</p> <p>¹⁷ <input type="checkbox"/> University of Melbourne (undergraduate)</p> <p>¹⁹ <input type="checkbox"/> University of Melbourne (postgraduate)</p> <p>²¹ <input type="checkbox"/> Monash University (undergraduate)</p> <p>²³ <input type="checkbox"/> Monash University (postgraduate)</p> <p>²⁴ <input type="checkbox"/> University of New England & University of Newcastle Joint Medical Program</p> | <p>² <input type="checkbox"/> University of Newcastle</p> <p>⁴ <input type="checkbox"/> University of Notre Dame WA</p> <p>⁶ <input type="checkbox"/> University of Notre Dame Sydney</p> <p>⁸ <input type="checkbox"/> University of NSW</p> <p>¹⁰ <input type="checkbox"/> University of Queensland</p> <p>¹² <input type="checkbox"/> University of Sydney</p> <p>¹⁴ <input type="checkbox"/> University of Tasmania</p> <p>¹⁶ <input type="checkbox"/> University of WA (undergraduate)</p> <p>¹⁸ <input type="checkbox"/> University of WA (postgraduate)</p> <p>²⁰ <input type="checkbox"/> University of Western Sydney</p> <p>²² <input type="checkbox"/> University of Wollongong</p> |
|---|---|

52. 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

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

- ¹ Yes
- ² No
- ³ Not Applicable

54. 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)

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

- ¹ Yes
- ² No
- ³ Unsure

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

	Number of qualifications	Names of qualifications
Masters degree	<input type="text"/>	<input type="text"/>
PhD	<input type="text"/>	<input type="text"/>
Postgraduate diploma/certificate	<input type="text"/>	<input type="text"/>
Fellowship of college	<input type="text"/>	<input type="text"/>

57. 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

58. Please indicate how many other health and non-health related qualifications you have obtained in Australia.

No. of qualifications.

59. Which specialty training program are you enrolled in?

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

60. In what year did you start this training program?

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

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

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

63. 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

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

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

65. 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

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

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

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

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

68. The statements below refer to the type of person you are. There is growing evidence that these characteristics are related to doctors' job satisfaction and decisions about work. The information you provide will remain strictly confidential and you will not be identifiable.

Please answer each of the following questions using a 1 to 7 point scale, where 1 means 'Does not apply to me at all' and 7 means 'Applies to me perfectly'.

	Does not apply to me at all	1	2	3	4	5	6	7	Applies to me perfectly					
I see myself as someone who:														
Does a thorough 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"/>	7	<input type="checkbox"/>
Is communicative, talkative	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"/>
Is sometimes somewhat rude to others	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"/>
Is original, comes up with new ideas	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"/>
Worries a lot	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"/>
Has a forgiving nature	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"/>
Tends to be lazy	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"/>
Is outgoing, sociable	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"/>
Values artistic experiences	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"/>
Gets nervous easily	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"/>
Does things effectively and efficiently	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"/>
Is reserved	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"/>
Is considerate and kind to others	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"/>
Has an active imagination	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"/>
Is relaxed, handles stress well	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"/>

DOCTOR ENROLLED IN A SPECIALTY TRAINING PROGRAM

69. 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	1	2	3	4	5	6	Strongly agree	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"/>
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"/>

70. 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"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>
Career and professional risks (e.g. publicly challenging your professional colleagues)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>
Clinical risks (e.g. recommending a treatment which is new to your usual practice or is controversial)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>

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

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

	No	Yes	If 'YES', please indicate how long ago it happened.									
			0 to 3 months ago	4 to 6 months ago	7 to 9 months ago	10 to 12 months ago						
Serious personal injury or illness to self	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Serious personal injury or illness to a close relative or family member	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Death of spouse or child	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Death of other close relative or family member (e.g. parent or sibling)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Death of a close friend	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Victim of physical violence (e.g. assault)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Victim of a property crime (e.g. theft, housebreaking)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
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)	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Had restrictions (e.g. undertakings, conditions, suspensions or cancellations) placed on your medical registration	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Named as defendant in a medical negligence claim	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>
Other (please specify) <input style="width: 150px;" type="text"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>

72. 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 1	Most of the time 2	Some of the time 3	A little of the time 4	None of the time 5
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless or fidgety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
So depressed that nothing could cheer you up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That everything was an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73. 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 76.)

A lot more often than usual 1	Somewhat more often than usual 2	A little more often than usual 3	About the same as usual 4	A little less often than usual 5	Somewhat less often than usual 6	A lot less often than usual 7	Never - Go to Q76 8
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74. 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).....

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

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

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

Email address:

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

.....

.....

.....

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.....

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.....

Completing this questionnaire may be distressful for some individuals. If you need urgent assistance, please contact Lifeline's 24-hour telephone crisis support service by calling 13 11 14. Information about depression, anxiety and related disorders and treatments can be obtained from Beyond Blue by calling 1300 224 636 or emailing infoline@beyondblue.org.au . For help and support from *Doctors' Health Services Pty Ltd* go to <https://www.doctorportal.com.au/doctorshealth/#> for the contact details of your local service.

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

