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MABEL

Medicine in Australia: Balancing Employment and Life
2012

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 state job title:

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

¹ Yes – *Please go to Section G and complete the final two sections of the survey*

² Unsure – *Please go to Section G and complete the final two sections of the survey*

³ No – *As you do not intend returning to clinical work in Australia you do not need to complete the rest of the survey. Please return this survey in the reply-paid envelope provided. Thank you for your participation.*

B About your job satisfaction

5. Please indicate how satisfied or dissatisfied you are with each of the various aspects of your work as a doctor.

	Very Dissatisfied	Moderately Dissatisfied	Not Sure	Moderately Satisfied	Very Satisfied	N/A
Freedom to choose your own method of working	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of variety in your work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Physical working conditions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Opportunities to use your abilities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your colleagues and fellow workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Recognition you get for good work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your hours of work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Your remuneration	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Amount of responsibility you are given	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Taking everything into consideration, how do you feel about your work?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The balance between my personal and professional commitments is about right	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I have a poor support network of other doctors like me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
It is difficult to take time off when I want to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
My patients have unrealistic expectations about how I can help them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The majority of my patients have complex health and social problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Running my practice is stressful most of the time	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Research publications are important to my career	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
The hours I work are unpredictable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
I often undertake tasks that somebody less qualified could do	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

7. Would you like to change your hours of work (including day time and after hours)?

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

C About the places where you work

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

	Actual hours per week
Public hospital (including psychiatric hospital)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Private hospital	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Private medical practitioner's rooms or surgery	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Residential/aged care health facility (nursing/residential home, hospice etc.)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Laboratory or radiology facility	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Community health centre	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Government department, agency or defence forces	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Tertiary education institution	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
TOTAL HOURS WORKED	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

9. Do you work in private practice?

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

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

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

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

No. of nurses

No. of allied health professionals

No. of administrative staff

No. of other staff

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

Yes

No

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

Principal or partner

Associate

Salaried employee (e.g. receive fixed annual salary & benefits with tax deducted)

Contracted employee (e.g. receive fixed payment per session or a % of billings before tax)

Locum

Other (please specify)

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

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

Hospital name

Postcode

16. How are you paid for this hospital work?

Fee-for-service/bill patients directly

Fixed payment per session or hour

Salary—no rights to private practice

Salary with rights to private practice

Other, please specify

D About your workload

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

TOTAL HOURS WORKED PER WEEK (Should equal the TOTAL in question 8) hrs/wk

Direct patient care (face-to-face, phone consultations, home visits: with or without a medical student present) hrs/wk

Indirect patient care (medical notes, reports, phone calls, meeting patients' families) hrs/wk

Education activities (teaching, research, continuing medical education) hrs/wk

Management and administration hrs/wk

Other hrs/wk

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

Teaching or supervising medical students

Teaching or supervising interns and pre-vocational trainees

Teaching or supervising specialist registrars

No, I am not involved in any teaching or supervision

SPECIALIST

19. 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.	<input style="width: 30px; height: 20px;" type="text"/>
Total number of public patients seen in a public hospital.	<input style="width: 30px; height: 20px;" type="text"/>
Total number of private patients seen in a public hospital	<input style="width: 30px; height: 20px;" type="text"/>
Total number of private patients seen in a private hospital	<input style="width: 30px; height: 20px;" type="text"/>

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

No. of days	<input style="width: 20px; height: 20px;" type="text"/>	days
No. of weeks	<input style="width: 20px; height: 20px;" type="text"/>	weeks
Not taking new patients at present (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	
Not Applicable (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	

21. How long does a standard private consultation last?

New patient/ Initial consultation	<input style="width: 20px; height: 20px;" type="text"/>	minutes
Subsequent consultations	<input style="width: 20px; height: 20px;" type="text"/>	minutes
Not Applicable (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	

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

Per cent	<input style="width: 30px; height: 20px;" type="text"/>	%
Not Applicable (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	

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

New patient/initial consultation.	\$	<input style="width: 40px; height: 20px;" type="text"/>
Subsequent consultations	\$	<input style="width: 40px; height: 20px;" type="text"/>
Not Applicable (Tick box)		<input style="width: 20px; height: 20px;" type="checkbox"/>

24. 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 28

25. 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 style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>
1 weekend in	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>
Not Applicable (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	

26. 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 style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>
Weekend: times per weekend	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>
Not Applicable (Tick box)	<input style="width: 20px; height: 20px;" type="checkbox"/>	

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

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

¹ Very limited

² Average

³ Very good

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

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.

30. 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) \$	<input type="text"/>		<input type="text"/>
After tax (net earnings) \$	<input type="text"/>		<input type="text"/>

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

¹ Yes

² No

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

33. 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)

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

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

¹ Sole trader

² Partnership

³ Company

⁴ Trust

⁵ Don't Know

⁶ Not Applicable

36. 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

37. 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)

38. 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 30. 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

39. In how many locations do you practise?

40. Where is your main place of work?
 Town/Suburb
 Postcode

41. Where do you live?
 Town/Suburb
 Postcode

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 don’t have many friends or family members in my current work location	1 <input style="width: 20px; height: 15px;" type="text"/>	2 <input style="width: 20px; height: 15px;" type="text"/>	3 <input style="width: 20px; height: 15px;" type="text"/>	4 <input style="width: 20px; height: 15px;" type="text"/>	5 <input style="width: 20px; height: 15px;" type="text"/>	6 <input style="width: 20px; height: 15px;" type="text"/>
It is easy to pursue my hobbies and leisure interests in my current work location	1 <input style="width: 20px; height: 15px;" type="text"/>	2 <input style="width: 20px; height: 15px;" type="text"/>	3 <input style="width: 20px; height: 15px;" type="text"/>	4 <input style="width: 20px; height: 15px;" type="text"/>	5 <input style="width: 20px; height: 15px;" type="text"/>	6 <input style="width: 20px; height: 15px;" type="text"/>
My partner does not have many friends or family members in this work location	1 <input style="width: 20px; height: 15px;" type="text"/>	2 <input style="width: 20px; height: 15px;" type="text"/>	3 <input style="width: 20px; height: 15px;" type="text"/>	4 <input style="width: 20px; height: 15px;" type="text"/>	5 <input style="width: 20px; height: 15px;" type="text"/>	6 <input style="width: 20px; height: 15px;" type="text"/>
There are good employment opportunities for my partner in this work location	1 <input style="width: 20px; height: 15px;" type="text"/>	2 <input style="width: 20px; height: 15px;" type="text"/>	3 <input style="width: 20px; height: 15px;" type="text"/>	4 <input style="width: 20px; height: 15px;" type="text"/>	5 <input style="width: 20px; height: 15px;" type="text"/>	6 <input style="width: 20px; height: 15px;" type="text"/>
The choice of schools for our children is adequate in this work location	1 <input style="width: 20px; height: 15px;" type="text"/>	2 <input style="width: 20px; height: 15px;" type="text"/>	3 <input style="width: 20px; height: 15px;" type="text"/>	4 <input style="width: 20px; height: 15px;" type="text"/>	5 <input style="width: 20px; height: 15px;" type="text"/>	6 <input style="width: 20px; height: 15px;" type="text"/>

43. 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 45

44. 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

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

1 Yes

2 No

G About your family circumstances

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

- ¹ Yes
² No

47. 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

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

49. 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

50. 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

51. 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

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 completed your medical degree outside of Australia:

What year did you first arrive in Australia?

In what year were you first registered to work as a doctor in Australia?

Not Applicable (Tick box)

SPECIALIST

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

	Number of qualifications (e.g. 1, 2 etc)	Name of degree (e.g. MBBS, FRACP)
Undergraduate degree	<input type="text"/>	<input style="width: 100%;" type="text"/>
Graduate entry medical degree	<input type="text"/>	<input style="width: 100%;" type="text"/>
Masters degree	<input type="text"/>	<input style="width: 100%;" type="text"/>
PhD	<input type="text"/>	<input style="width: 100%;" type="text"/>
Postgraduate diploma/certificate	<input type="text"/>	<input style="width: 100%;" type="text"/>
Fellowship of college	<input type="text"/>	<input style="width: 100%;" type="text"/>
Others	<input type="text"/>	<input style="width: 100%;" type="text"/>
I have qualifications from overseas which are recognised in Australia (Tick box)		<input type="checkbox"/>

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

- 1 Yes
- 2 No
- 3 Unsure

56. 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
INTERNAL MEDICINE:		
Cardiology	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Clinical genetics	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Clinical haematology	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Clinical immunology (incl. allergy)	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Clinical pharmacology	5 <input type="checkbox"/>	5 <input type="checkbox"/>
Endocrinology	6 <input type="checkbox"/>	6 <input type="checkbox"/>
Gastroenterology	7 <input type="checkbox"/>	7 <input type="checkbox"/>
General medicine	8 <input type="checkbox"/>	8 <input type="checkbox"/>
Geriatrics	9 <input type="checkbox"/>	9 <input type="checkbox"/>
Infectious diseases	10 <input type="checkbox"/>	10 <input type="checkbox"/>
Intensive care—internal medicine	11 <input type="checkbox"/>	11 <input type="checkbox"/>
Medical oncology	12 <input type="checkbox"/>	12 <input type="checkbox"/>
Neurology	13 <input type="checkbox"/>	13 <input type="checkbox"/>
Nuclear medicine	14 <input type="checkbox"/>	14 <input type="checkbox"/>
Paediatric medicine	15 <input type="checkbox"/>	15 <input type="checkbox"/>
Renal medicine	16 <input type="checkbox"/>	16 <input type="checkbox"/>
Rheumatology	17 <input type="checkbox"/>	17 <input type="checkbox"/>
Thoracic medicine	18 <input type="checkbox"/>	18 <input type="checkbox"/>
PATHOLOGY:		
General pathology	19 <input type="checkbox"/>	19 <input type="checkbox"/>
Anatomical pathology	20 <input type="checkbox"/>	20 <input type="checkbox"/>
Clinical chemistry	21 <input type="checkbox"/>	21 <input type="checkbox"/>
Cytopathology	22 <input type="checkbox"/>	22 <input type="checkbox"/>
Forensic pathology	23 <input type="checkbox"/>	23 <input type="checkbox"/>
Haematology	24 <input type="checkbox"/>	24 <input type="checkbox"/>
Immunology	25 <input type="checkbox"/>	25 <input type="checkbox"/>
Microbiology	26 <input type="checkbox"/>	26 <input type="checkbox"/>

SPECIALIST

Main speciality in which
you practise (Where you are
qualified & recognised under the
Health Insurance Act)

Second specialty
in which you practise

SURGERY:

- | | | | | | |
|--|----|--------------------------|--|----|--------------------------|
| General surgery | 27 | <input type="checkbox"/> | | 27 | <input type="checkbox"/> |
| Cardiothoracic surgery | 28 | <input type="checkbox"/> | | 28 | <input type="checkbox"/> |
| Orthopaedic surgery | 29 | <input type="checkbox"/> | | 29 | <input type="checkbox"/> |
| Otolaryngology | 30 | <input type="checkbox"/> | | 30 | <input type="checkbox"/> |
| Paediatric surgery | 31 | <input type="checkbox"/> | | 31 | <input type="checkbox"/> |
| Plastic/reconstructive surgery | 32 | <input type="checkbox"/> | | 32 | <input type="checkbox"/> |
| Urology | 33 | <input type="checkbox"/> | | 33 | <input type="checkbox"/> |
| Neurosurgery | 34 | <input type="checkbox"/> | | 34 | <input type="checkbox"/> |
| Vascular surgery | 35 | <input type="checkbox"/> | | 35 | <input type="checkbox"/> |

OTHER SPECIALTIES:

- | | | | | | |
|--|----|--------------------------|--|----|--------------------------|
| Anaesthesia (excl. intensive care) | 36 | <input type="checkbox"/> | | 36 | <input type="checkbox"/> |
| Dermatology | 37 | <input type="checkbox"/> | | 37 | <input type="checkbox"/> |
| Diagnostic radiology (incl. ultrasound) | 38 | <input type="checkbox"/> | | 38 | <input type="checkbox"/> |
| Emergency medicine | 39 | <input type="checkbox"/> | | 39 | <input type="checkbox"/> |
| Intensive care—anaesthesia | 40 | <input type="checkbox"/> | | 40 | <input type="checkbox"/> |
| Medical administration | 41 | <input type="checkbox"/> | | 41 | <input type="checkbox"/> |
| Obstetrics and gynaecology (incl. gynaecological oncology) | 42 | <input type="checkbox"/> | | 42 | <input type="checkbox"/> |
| Occupational medicine | 43 | <input type="checkbox"/> | | 43 | <input type="checkbox"/> |
| Ophthalmology | 44 | <input type="checkbox"/> | | 44 | <input type="checkbox"/> |
| Psychiatry | 45 | <input type="checkbox"/> | | 45 | <input type="checkbox"/> |
| Public health medicine | 46 | <input type="checkbox"/> | | 46 | <input type="checkbox"/> |
| Radiation oncology | 47 | <input type="checkbox"/> | | 47 | <input type="checkbox"/> |
| Rehabilitation medicine | 48 | <input type="checkbox"/> | | 48 | <input type="checkbox"/> |
| Sport and exercise medicine | 49 | <input type="checkbox"/> | | 49 | <input type="checkbox"/> |
| OTHER SPECIALTY not specified above | 50 | <input type="checkbox"/> | | 50 | <input type="checkbox"/> |

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

- Australian citizen
- Permanent resident
- Temporary resident

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

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

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

- Excellent
- Very good
- Good
- Fair
- Poor

