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# MABEL

Medicine in Australia: Balancing Employment and Life

2011

## General Practitioner & GP Registrar

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

**MABEL has been endorsed by:**

Royal Australian College of General Practitioners  
Australian College of Rural and Remote Medicine

Rural Doctors Association of Australia  
Rural Health Workforce Australia

Australian General Practice Training  
Australian General Practice Network

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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?

<sup>1</sup>  Yes – If yes, please go to Section B below and complete the main survey

<sup>2</sup>  No – Continue

2. Are you permanently retired from all types of paid work?

<sup>1</sup>  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.

<sup>2</sup>  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?

<sup>1</sup>  Yes – Please go to Section G and complete the final two sections of the survey

<sup>2</sup>  Unsure – Please go to Section G and complete the final two sections of the survey

<sup>3</sup>  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 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	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Amount of variety in your work	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Physical working conditions	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Opportunities to use your abilities	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Your colleagues and fellow workers	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Recognition you get for good work	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Your hours of work	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Your remuneration	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Amount of responsibility you are given	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
Taking everything into consideration, how do you feel about your job?	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <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 amount of work I delegate to other health professionals has increased in the past 12 months	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 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"/>
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"/>
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 have good supervision/mentoring support	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"/>
I normally consult with others in the practice about the management of patients with 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"/>
Formal structures are in place to encourage communication amongst practice staff (e.g. regular meetings)	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

8. 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"/>

## C About the places where you work

9. 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
Private medical practitioner's rooms or surgery	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Community health centre or other state-run primary care organisation	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
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
Residential/aged care health facility (nursing/residential home, hospice etc.)	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Aboriginal health service	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Government department, agency or defence forces	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Tertiary education institution	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
Other	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk
TOTAL HOURS WORKED	<input type="text"/> <input type="text"/> <input type="text"/> hrs/wk

10. How many GPs work in your current main practice? (Include yourself if applicable) (If none, write 0)

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

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

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

12. Is your current main practice co-located with other health or welfare professionals?

<sup>1</sup>  Yes  
<sup>2</sup>  No

13. What is your business relationship with the practice? (Tick one box)

<sup>1</sup>  Principal or partner  
<sup>2</sup>  Associate  
<sup>3</sup>  Salaried employee (e.g. receive fixed annual salary & benefits with tax deducted)  
<sup>4</sup>  Contracted employee (e.g. receive fixed payment for specified time or a % of billings before tax)  
<sup>5</sup>  Locum  
<sup>6</sup>  Other (please specify)

14. When did you start working at this practice?

Month . . . . .   
Year . . . . .

15. My opportunities for continuing medical education and professional development are:

<sup>1</sup>  Very limited  
<sup>2</sup>  Average  
<sup>3</sup>  Very good

16. Do you currently work in a hospital?

<sup>1</sup>  Yes  
<sup>2</sup>  No— Go to question 20

17. How are you paid for this hospital work?

<sup>1</sup>  Fee-for-service/bill patients directly  
<sup>2</sup>  Fixed payment per session or hour  
<sup>3</sup>  Salary with rights to private practice  
<sup>4</sup>  Other (please specify)

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

Hospital name . . . . .   
Postcode . . . . .

19. How long have you worked at this hospital?

No. of years . . . . .   
No. of months . . . . .

## D About your workload

20. 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 9) . . . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	hrs/wk
Direct patient care (face-to-face, phone consultations, home visits: with or without a medical student present) . . . . .	<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 (teaching, 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

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

- Teaching medical students
- Teaching interns or other pre-vocational trainees
- Teaching registrars
- No, I am not involved in any teaching

22. Do you practise in any of the following areas? (Tick all that apply)

- Anaesthetics
- Obstetrics
- Surgery
- Emergency medicine
- None of the above

23. 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 type="text"/>	<input type="text"/>	<input type="text"/>
Total number of patients seen in hospital or other settings . . . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>

24. Excluding emergencies or urgent needs, for how many days does a patient typically have to wait for an appointment with: (Please write average number of days)

You, their preferred doctor in the practice? . . . . .	<input type="text"/>	<input type="text"/>	days
Any doctor in the practice? . . . . .	<input type="text"/>	<input type="text"/>	days

25. How long does a NEW patient typically have to wait for an appointment in your practice?

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

26. How long does an average consultation last? (Please write number of minutes) . . . . .  mins

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

28. What is your current fee for a standard (level B) consultation? (Include Medicare rebate and patient co-payment. Please write dollar amount; write 0 if you bulk bill 100% of your patients) . . . \$

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

- <sup>1</sup>  Yes
- <sup>2</sup>  No—Go to question 33

30. What are your on-call ratios for practice and hospital work?

	Practice work	Hospital work
1 weeknight in . . . . .	<input type="text"/>	<input type="text"/>
1 weekend in . . . . .	<input type="text"/>	<input type="text"/>
Not Applicable (Tick box) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

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

	Practice work	Hospital work
Weeknights: times per week .....	<input type="text"/>	<input type="text"/>
Weekend: times per weekend .....	<input type="text"/>	<input type="text"/>
Not Applicable (Tick box) .....	<input type="checkbox"/>	<input type="checkbox"/>

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

33. Arranging a locum at short notice is usually: (Tick one box)

- Moderately easy
- Rather difficult
- Very difficult
- Not Applicable

34. 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

35. How many vacancies for GPs does your (main) practice currently have advertised or registered with a recruitment or workforce agency? (If none, write 0)

No. of vacancies .....

No. of these vacancies which have been unfilled for three months or more? .....

Don't Know (Tick box) .....

Not Applicable (Tick box) .....

## E About your finances

The following information will be used to examine the effect of financial issues on your work-life balance, and will remain strictly confidential.

36. 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"/>

37. 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)?

- Yes
- No

38. What is the approximate annual total value in dollars of these benefits?

(If zero, write 0) .....

39. 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) .....

40. 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) .....

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

- Sole trader
- Partnership
- Company
- Trust
- Don't Know
- Not Applicable

42. 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.)

- Yes
- No

43. In the last year, approximately what percentage of your total gross earnings did you receive from each of the following sources? (Please enter percentage figure where applicable)

Payments from patients for services covered by Medicare (include Medicare rebate and patient co-payment) .....  %

Payments from patients for services not covered by Medicare (e.g. insurance, certificates, private patients) .....  %

Government incentive schemes and grants (e.g. rural incentives) .....  %

Hospital work (salary and other payments) .....  %

Other sources (including non-medical/business; specify source and %)   %

TOTAL .....  100 %

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

- Yes
- No—Go to question 46

45. For how many years have you (and/or an employer on your behalf) contributed to a superannuation scheme?

No. of years .....

46. 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)

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

47. 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) .....

48. 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 36. 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

49. In how many locations do you practise? .....

50. Where is your main place of work?

Town/Suburb .....

Postcode .....

51. How long have you been practising in or close to this geographic location?

No. of years .....

No. of months .....

52. Where do you live?

Town/Suburb .....

Postcode .....

53. The opportunities for social interaction for you and your family in the geographic location of your main job are:

(Tick one box)

Very limited

Average

Very good

54. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy to pursue my hobbies and leisure interests in my current work location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My partner does not have many friends or family members in this work location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are good employment opportunities for my partner in this work location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The choice of schools for our children is adequate in this location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Town .....

State .....

Not Applicable (Tick box) .....

57. Are you subject to restrictions on where you practise?

Yes—I am required to work in an Area of Need

Yes—I am required to work in a District of Workforce Shortage

No—Go to question 59

58. 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

Not Applicable



## G About your family circumstances

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

- <sup>1</sup>  Yes <sup>2</sup>  No

60. What is the employment status of your partner/spouse?

- <sup>1</sup>  Not in the labour force (e.g. caring for dependents, studying)  
<sup>2</sup>  Currently seeking work  
<sup>3</sup>  Full-time employment  
<sup>4</sup>  Part-time employment  
<sup>5</sup>  Not Applicable

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

- <sup>1</sup>  Yes <sup>2</sup>  No <sup>3</sup>  Not Applicable

62. 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) .....

63. 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) .....

64. How many dependent children do you have? .....

65. 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.....

66. 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

67. 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	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <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	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>
My partner is overqualified for his/her current job due to the limited availability of suitable jobs	<sup>1</sup> <input type="checkbox"/>	<sup>2</sup> <input type="checkbox"/>	<sup>3</sup> <input type="checkbox"/>	<sup>4</sup> <input type="checkbox"/>	<sup>5</sup> <input type="checkbox"/>	<sup>6</sup> <input type="checkbox"/>

**H** About you

68. Year of birth .....

69. Gender

- Male
- Female

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

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

- A medical school in Australia
- A medical school in the country specified:

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

- |  |   |
|--|---|
| <input type="checkbox"/> Not Applicable  | <input type="checkbox"/> University of Newcastle          |
| <input type="checkbox"/> University of Adelaide  | <input type="checkbox"/> University of Notre Dame WA      |
| <input type="checkbox"/> Australian National University  | <input type="checkbox"/> University of Notre Dame Sydney  |
| <input type="checkbox"/> Bond University   | <input type="checkbox"/> University of NSW                |
| <input type="checkbox"/> Deakin University   | <input type="checkbox"/> University of Queensland         |
| <input type="checkbox"/> Flinders University   | <input type="checkbox"/> University of Sydney             |
| <input type="checkbox"/> Griffith University   | <input type="checkbox"/> University of Tasmania           |
| <input type="checkbox"/> James Cook University   | <input type="checkbox"/> University of WA (undergraduate) |
| <input type="checkbox"/> University of Melbourne (undergraduate)                                   | <input type="checkbox"/> University of WA (postgraduate)  |
| <input type="checkbox"/> University of Melbourne (postgraduate)                                    | <input type="checkbox"/> University of Western Sydney     |
| <input type="checkbox"/> Monash University (undergraduate)   | <input type="checkbox"/> University of Wollongong         |
| <input type="checkbox"/> Monash University (postgraduate)  |   |
| <input type="checkbox"/> University of New England & University of Newcastle Joint Medical Program |   |

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

- Yes
- No
- Not Applicable

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

- Yes
- No
- Unsure

75. What GP and other medical qualifications have you obtained in Australia (e.g. FRACGP, FRACP, FACRRM, diploma)?

- 1 .....
- 2 .....
- 3 .....
- 4 .....
- 5 .....

- None: I am currently a GP registrar (Tick box) .....
- None: I have qualifications from overseas which are recognised in Australia (Tick box) .....
- Not Applicable (Tick box) .....

76. If you are a GP Registrar:  
 In what year did you start this training program? .....       
 In what year do you expect to complete the program and become a Fellow? .....       
 Not Applicable (Tick box) .....

77. 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 .....

78. What is your residency status? (Tick one box)  
<sup>1</sup>  Australian citizen  
<sup>2</sup>  Permanent resident  
<sup>3</sup>  Temporary resident

79. What type of medical registration do you have?  
<sup>1</sup>  Full (unconditional) medical registration  
<sup>2</sup>  Conditional medical registration  
<sup>3</sup>  Other (please specify)

80. In general, would you say your health is: (Tick one box)  
<sup>1</sup>  Excellent  
<sup>2</sup>  Very good  
<sup>3</sup>  Good  
<sup>4</sup>  Fair  
<sup>5</sup>  Poor

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

Completely Dissatisfied											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"/>	<input type="checkbox"/>	

82. 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							Applies to me perfectly
	1	2	3	4	5	6	7	
I see myself as someone who:								
Does a thorough job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is communicative, talkative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is sometimes somewhat rude to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is original, comes up with new ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a forgiving nature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tends to be lazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is outgoing, sociable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Values artistic experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets nervous easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does things effectively and efficiently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is reserved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is considerate and kind to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has an active imagination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is relaxed, handles stress well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

83. 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 style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
There is really no way I can solve some of the problems I have	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
There is little I can do to change many of the important things in my life	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
I often feel helpless in dealing with the problems of life	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
Sometimes I feel that I'm being pushed around in life	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
What happens to me in the future mostly depends on me	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	
I can do just about anything I really set my mind on doing	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>	5 <input style="width: 30px; height: 20px;" type="checkbox"/>	6 <input style="width: 30px; height: 20px;" type="checkbox"/>	7 <input style="width: 30px; height: 20px;" type="checkbox"/>	

84. 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.

			If 'YES', please indicate how long ago it happened.			
	Yes	No	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 style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Serious personal injury or illness to a close relative or family member	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Death of spouse or child	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Death of other close relative or family member (e.g. parent or sibling)	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Death of a close friend	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Victim of physical violence (e.g. assault)	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Victim of a property crime (e.g. theft, housebreaking)	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>
Named as defendant in a medical negligence claim	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	1 <input style="width: 30px; height: 20px;" type="checkbox"/>	2 <input style="width: 30px; height: 20px;" type="checkbox"/>	3 <input style="width: 30px; height: 20px;" type="checkbox"/>	4 <input style="width: 30px; height: 20px;" type="checkbox"/>

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

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In case of loss of included reply-paid envelope, please forward survey to:  
 Melbourne Institute of Applied Economic and Social Research – MABEL Survey  
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