

Australian Medical Workforce Advisory Committee

CAREER DECISION MAKING BY POSTGRADUATE DOCTORS

AMWAC MEDICAL CAREERS SURVEYS, 2004

KEY FINDINGS

AMWAC Report 2005.3

December 2005

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ISBN 0 7347 3907 9

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Suggested citation:

Australian Medical Workforce Advisory Committee (2005), Career Decision Making by Postgraduate Doctors, Key Findings. AMWAC 2005.3, Sydney

This is a companion report to the Australian Medical Workforce Advisory Committee (2005), Career Decision Making by Postgraduate Doctors, Main Report. AMWAC 2005.3, Sydney.

Publication by Australian Medical Workforce Advisory Committee.

Printing by Ligare.

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This document presents the key findings from two surveys undertaken by the Australian Medical Workforce Advisory Committee (AMWAC) in 2004:

1. Wave 2 survey of doctors participating in the AMWAC longitudinal study. These doctors were first surveyed in 2002 (Wave 1 survey); and
2. A survey (snapshot) of all recent entrants to vocational training.

For those readers requiring more detailed information about this project, the full 'Summary of Findings' is available in hard copy from the National Health Workforce Secretariat, so too is the full report 'Career Decision Making by Postgraduate Doctors in their Early Postgraduate Years' (AMWAC report 2005.3). All three documents are available at www.healthworkforce.health.nsw.gov.au.

Background

As outlined in Box S1 these two surveys represent Stage 3 of an AMWAC project that was commenced in 2002. The purpose of the project is to provide advice to the Australian Health Ministers' Advisory Council on factors influencing the career choice and workforce participation decisions of postgraduate doctors. Of most relevance to workforce planning are the extrinsic factors influencing:

- choice of discipline;
- workforce attrition/retention;
- hours of work;
- type of medical practice; and
- location of practice (State/Territory and geographic).

Intrinsic factors (such as skills and aptitudes and personal preferences) are also of interest, but are less amenable to influence by policy makers.

The project builds on earlier AMWAC studies on female participation in the medical workforce (AMWAC Report 1996.7), and factors influencing workforce participation and changes occurring in the characteristics of Australian medical students (AMWAC/AIHW Report 1997.7). The first of these studies recommended that 'AMWAC coordinate a historical/cohort study of medical practitioners from graduation throughout their medical careers to identify factors which determine career choice and examine concerns about non-participation in the workforce'. Box S1 outlines the first three stages of the project.

Box S1: Summary of events associated with the AMWAC medical careers project

2002 Stage 1	Career decision making by doctors in the early postgraduate years - A literature review,' (AMWAC Report 2002.1)
2002 Stage 2	Wave 1 survey – a national survey of 7,906 doctors in vocational training in September 2002: 4,295 (54%) responded 'Career Decision Making by Doctors in Vocational Training,' (AMWAC Report 2003.1). In 2002, 4,017 survey respondents agreed to participate in a longitudinal cohort study, and in 2004, 3,946 (98.2%) of these doctors were able to be contacted.
2004 Stage 3	1) <u>Wave 2 survey</u> – second survey of the 2002 cohort of doctors who agreed to participate in the longitudinal study and were able to be contacted. In total 71.4% (2,817/3946) responded. This figure represented 35.6% of the original 2002 target population. The 2004 survey included doctors who: 1) had completed vocational training since September 2002; 2) were still undertaking vocational training in 2004, 3) were working or studying overseas, and 4) had left medicine altogether. 2) <u>2004 survey of recent entrants to vocational training</u> A survey of the 3,075 doctors who had commenced vocational training since September 2002. In total, 1,712 (57.4%) responded. This survey provided an opportunity to compare 'snapshot' information obtained from two separate groups of doctors in vocational training at two points in time (2002 and 2004).

Key findings

This section first analyses the response to the two AMWAC 2004 surveys and then provides a summary of the key findings using the following headings: 1) background characteristics, 2) career status and progression, 3) choice of discipline, 4) hours of work, 5) type of medical work, 6) location of practice, 7) training and work environment, and 8) workforce attrition/retention.

Response rate analysis

- As indicated in Box S1, 2,817 doctors responded to the Wave 2 (2004) survey and this figure represented 71.4% of doctors who responded to the Wave 1 (2002) survey (and who agreed to participate in the longitudinal study) and 35.6% of the original target population of all doctors in vocational training in September 2002.
- Tables 1 and 2 (Attachment 1) show that the specialty and age and sex profiles of the Wave 2 respondents were reasonably consistent with the original target population. Of note was the relatively low representation of surgeons compared with their representation in the target population and the relatively high representation of women among respondents in both 2002 and 2004 compared with their representation in the target population.
- The Working Party concluded that the specialty profile and demographic profile of Wave 2 respondents were sufficiently consistent with the profile of the original cohort to provide representative data of factors influencing the career decisions of postgraduate doctors in 2004.
- Box S1 indicates that the 2004 survey of recent entrants to vocational training achieved a 57.4% response and Tables 3 and 4 show that the specialty and age profiles of respondents were consistent with the target population while the representation of

women among respondents was relatively high compared with their representation in the target population.

Background characteristics

- Wave 2 (2004) survey respondents were, on average, one year older than respondents to the survey of recent entrants to vocational training and a higher proportion were married/partnered and had dependent children (Table 5, Attachment 2).
- A higher proportion of recent entrant respondents (21.9%) than Wave 2 respondents (13.2%) were International Medical Graduates (Table 5, Attachment 2).
- A higher proportion of recent entrant respondents (46.1%) than Wave 2 respondents (18.5%) had a debt burden associated with their medical education and training greater than \$10,000 (Table 5, Attachment 2).

Career status and career progress

Career status

- By 2004, 35% of Wave 2 survey respondents had completed vocational training, 62.9% were in vocational training, 1.4% had left vocational training without completing the program and 0.6% had left medicine altogether (Table 6, Attachment 2).
- In total, 6% of Wave 2 respondents were taking a break; 70% of whom were women.
- The majority (96%) of recent entrant respondents were practising in a vocational training program, 3.6% were taking a break and 0.4% had left medicine altogether (Table 6, Attachment 2).

Career progression

- By 2004, the career progress of 67% of Wave 2 respondents was consistent with their expectations in 2002. However, of Wave 2 respondents still in vocational training in 2004, 48% (790/1653) were taking longer to complete vocational training than they had previously expected and part-time training and taking time-out were factors associated with the delay.

Choice of discipline

- In total, 83.6% of Wave 2 respondents were in seven specialties: general practice, adult medicine, surgery, anaesthesia, emergency medicine, psychiatry and paediatrics and child health (Table 7, Attachment 2).
- The specialty profile of recent entrant respondents was different to that of Wave 2 survey respondents. For example, 31.5% of recent entrants were GPET trainees, while 17.5% of Wave 2 survey respondents were general practice trainees or qualified general practitioners.

Stage of career when chose specialty

- Among recent entrant respondents, 58% had chosen their specialty by the end of Postgraduate Year 2 (PGY2) and a further 19% by the end of PGY 3. Comparative figures from the 2002 survey were 59.3% and 19.8% respectively.

Factors influencing choice of specialty

- In total, 78.1% of recent entrant respondents rated 'appraisal of own skills and aptitudes' as influential in their choice of specialty followed by 'Interest in helping people' (73.4% and 'Intellectual content of the specialty' (73.3%). These three intrinsic factors were similarly rated by respondents in 2002.

- The most influential extrinsic determinants of choice of specialty among recent entrant respondents in 2004 were the work culture typical of the specialty, opportunity to work flexible hours, hours of work typical of the specialty, work experience since graduation, the kinds of patients typical of the specialty, opportunity for procedural work and influence of consultant/mentors. These factors were also ranked among the top seven by doctors in vocational training in 2002.
- In 2004 and 2002, women rated hours of work typical of the discipline, opportunity to work flexible hours, and appraisal of own domestic circumstances, more highly than men, while men rated opportunity for procedural work, perceived prestige of the discipline, and perceived financial and career advancement prospects more highly than women.

Satisfaction with choice of specialty

- The majority (86%) of the 4,529 postgraduate doctors participating in the two AMWAC surveys in 2004 were satisfied or very satisfied with the specialty they had selected.
- Between 2002 and 2004, 8% of Wave 2 respondents had changed specialty. Reasons for a change in specialty included:
 - planned career decision;
 - better working environment;
 - less stressful work environment;
 - greater flexibility in work hours and in combining work and training;
 - failure to progress in preferred discipline.
- Among Wave 2 respondents, satisfaction with choice of specialty was a predictor of the decision to ($p < 0.01$):
 - continue in, or change specialty;
 - leave the training program without completing it;
 - take a break from training; or
 - leave medicine altogether.

Hours of work

Hours worked, 2002 and 2004

- There was an overall reduction of 1.8 hours (from 49.9 to 48.1), on average, worked per week by Wave 2 respondents between 2002 and 2004 ($p < 0.01$).
- Male and female Wave 2 respondents, single and married doctors, doctors with no dependent children and doctors with one to two dependent children were working fewer hours, on average, per week in 2004 than in 2002. Doctors with three or more children were working 1.4 hours longer, on average, per week.
- Wave 2 respondents who had completed vocational training and were practising as qualified specialists were, on average, working 3.1 fewer hours per week in 2004 than they were in 2002 (viz., from 46.3 to 43.2).
- On the other hand, there was an increase of 1.9 hours in the average hours worked per week by the 1,441 Wave 2 respondents in full-time vocational training in 2004 (viz., from 50.6 hours per week in 2002 to 52.5 hours in 2004 with wide variation across specialties).
- Between 2004 and 2002, the proportion of Wave 2 respondents (still in vocational training in 2004) who were training part-time increased from 8.6% to 13.6% and this increase was associated with a reduction of 2.6 in the number of hours worked, on average, per week, by all doctors still in vocational training in 2004.
- Recent entrant respondents worked, on average, 1.2 hours less in 2004 (47.2 hours) than their counterparts in 2002 (48.4 hours) and 77% were satisfied with the number of

hours they were working. Female trainees were less satisfied than male trainees and doctors with dependent children were less satisfied than those with no dependent children ($p < 0.01$).

- Male recent entrant respondents in 2004 worked fewer hours per week (49.2, on average) than doctors in vocational training in 2002 (51.3). The reverse was the case for female respondents, however, who worked more hours per week (46.8, on average in 2004) than their counterparts in 2002 (44.9 hours).
- Of recent entrant respondents in 2004, 6.5% were training part-time or in a job-share arrangement. The comparative 2002 figure was 9.4%.

Enactment of career plans re hours of work

- Of Wave 2 respondents who by 2004 were working as qualified specialists, their stated 2002 'long-term' intentions re hours of work was predictive of actual hours worked in 2004 ($p < 0.01$).

Hours worked and stress

- As in 2002, both 2004 surveys found an association between stress scores and:
 - number of hours worked, on average, per week ($p < 0.01$); and
 - satisfaction with hours of work ($p < 0.01$).
- Between 2002 and 2004, there was a significant decrease in the proportion of Wave 2 respondents with high to very high stress scores ($p < 0.01$), (from 56.4% to 46.3%). Wave 2 respondents who had completed vocational training had significantly lower stress scores than doctors still in vocational training ($p < 0.01$).
- Using linked data from the Wave 1 and Wave 2 surveys, the study found that an increase in work hours was predictive of an increase in stress scores ($p < 0.01$).
- Of recent entrant respondents in 2004, 48.4% had high to very high stress scores. The comparative figure for 2002 was 55.8%.

Future intentions re hours of work

- Of Wave 2 respondents who were:
 - working as qualified specialists in 2004, 32% of men and 53% of women planned to change their current work hours over the following two years, mainly toward reducing their hours.
 - in vocational training in 2004, there was a reduction in the proportion planning to work 45 hours or more per week over the following two years (from 35.8% to 29%) and an increase in the proportion planning to work less than 40 hours per week (from 42.3% to 48.2%).
- Of recent entrant respondents:
 - 22.8% planned to work part-time in the following 3-7 years (13.5% of men and 36.7% of women).
 - 49.4% planned to work less than 40 hours per week in the following 3-7 years (31.8% of men and 66.9% of women).
- Reasons for reducing work hours in the future included to: reduce stress, prevent burnout, care for children, have more time for family and friends and achieve a more balanced lifestyle.

Type of medical work

- In 2004 the majority (84.3%) of Wave 2 respondents who were qualified general practitioners were working in private clinical practice (35.8% in a practice of less than 4 doctors and 48.5% in a practice of 5 or more doctors). Based on their 2002 intentions, more than planned were working in private clinical practice.
- In 2004, the majority (72.5%) of Wave 2 respondents who were working as qualified specialists in a specialty other than general practice, had either a public hospital clinical appointment (43.3%), or were doing a mixture of public/private clinical work (29.2%). Based on their 2002 intentions, fewer than planned were undertaking a mixture of public/private clinical work and more than planned had a public hospital clinical appointment.

Location of medical work

State/Territory of medical work

- Of Wave 2 respondents who by 2004 were working as qualified specialists, their stated 2002 long-term intention of State/Territory of medical work was predictive of State/Territory of medical work in 2004 ($p < 0.01$).
- Of Wave 2 respondents still in vocational training in 2004, their stated long-term plans re State/Territory of medical work indicated a distributional profile consistent with the profile of the Australian population. This was also the situation with recent entrants to vocational training.

Urban/rural location of medical work

- Of the 163 Wave 2 respondents working as qualified specialists in 2004, who in 2002 indicated a preference for working in a rural area, 56% (92) were working in a rural area in 2004. In addition, 6% (51) of the 814 respondents who had indicated a preference to work in an urban location were also working in a rural area.
- Rural background was associated with working in a rural location ($p < 0.01$).
- Only 41.6% of rural based Wave 2 respondents working as qualified specialists in 2004 were satisfied with access to professional development activities, compared with 80.7% of those working in a capital city. This variation in satisfaction applied to both general practitioners and other specialists ($p < 0.01$).

Urban/rural long-term plans (next 3-7 years)

- Of Wave 2 respondents who were:
 - working as qualified specialists in 2004, 143/1012 (14%) were working in a rural location and 37 (25.9%) of these doctors planned to change their location in the following two years.
 - still in vocational training in 2004, 12.8% (222) had plans to work in a rural or remote location and of the 214 who in 2002 thought they would most like to do so in the long-term, 127 (59.4%) remained committed to these plans.
- Of recent entrant respondents:
 - 16% (including 30.3% of GPET trainees) indicated a preference to work in a rural or remote location;
 - positive associations ($p < 0.01$) were observed between preference to work in a rural or remote location and 1) rural background, 2) rural education and training experiences, and 3) rural scholarship/cadetship.
- The questionnaire asked respondents to rank five sets of potential reasons for choosing to work in a particular location using factors derived from an analysis of the qualitative

data provided by 2002 survey participants. The overall rankings from participants to both surveys were as follows:

1. Family and/or social considerations (including proximity to family and friends and children's education and career opportunities);
 2. Consideration for my career (including personal career aspirations/opportunity for advancement, availability of facilities/equipment//professional support, access to continuing professional development, diversity of work, opportunity to use qualifications/skills, government policy constraints and income);
 3. Lifestyle (including preference for living in geographic environment, and access to arts/entertainment/sporting activities);
 4. Consideration for my partner's career; and
 5. Other.
- Variation in the rankings of the above factors was observed based on sex, marital status and number of dependent children. For example, single men ranked 'Consideration for my career' as number 1 followed by 'Lifestyle', while married men with children ranked 'Family and/or social considerations' as number 1, then 'Consideration for my career', followed by 'Lifestyle' and then 'Consideration for my partner's career'. Married women with dependent children, on the other hand, ranked 'Family and/or social considerations' as number 1 followed by 'Consideration for my partner's career', then 'Lifestyle' followed by 'Consideration for my career'.

Education and work environment

Education and training environment

- Of Wave 2 respondents still in vocational training in 2004:
 - there was a significant increase ($p < 0.01$) in the proportion receiving most of their education and training from consultants (from 73.4% in 2002 to 80.2% in 2004) and a decrease in the proportion receiving it from senior registrars (from 11.8% to 2.7%);
 - there was a significant decrease ($p < 0.01$) between 2002 and 2004 in the proportion satisfied or very satisfied with the overall training that they were receiving, respectively, from 72.5% to 64.9%. The reasons for this decrease in satisfaction are not known.
- The majority (87.9%) of recent entrant respondents were training in their program of first choice.
- Of recent entrant respondents:
 - 70% were satisfied or very satisfied with their education and training program overall, while 10.4% were dissatisfied or very dissatisfied;
 - The least satisfying features of their education and training program were 'time and support to develop skills in areas such as research etc' (34.8% satisfied/very satisfied) and 'time and support to participate in formal educational activities' (54.9% satisfied and very satisfied);
 - those aged 30-39 years were less satisfied than those aged 40 years and over and those aged under 30 years with the training they were receiving 'overall' and with formal supervision and quality of formal educational activities ($p < 0.01$). The reasons for this variation are not known;
 - 46.1% had a financial debt associated with their education and training program of more than \$10,000 and these respondents were less satisfied with both 'access to formal educational activities' and the 'quality of formal educational activities' ($p < 0.01$). Reasons for this variation in satisfaction with features of their education and training program based on level of debt are not known.

Work environment

- Although starting from a low base, between 2002 and 2004, there was a significant increase in the proportion of Wave 2 respondents satisfied or very satisfied with their pay (from 42.9% to 50.9%) and with time for family and social and recreational activities (from 33.9% to 40.9%). Analysis of the data by career status indicated that satisfaction with these two features of the work environment had increased most markedly for those respondents who had completed vocational training during the previous two years.
- Among Wave 2 respondents, satisfaction with features of the work environment increased between 2002 and 2004 for all nine features except supervision.
- Of recent entrant respondents:
 - 65.5% were satisfied or very satisfied with their 'overall' working conditions;
 - 76.8%, 69.6% and 68.2%, respectively, were satisfied with 'support from medical staff in your discipline', 'support from nursing staff' and 'support from allied health staff';
 - 53.4% were satisfied with recognition and 44.2% were satisfied with pay.
- As in 2002, both 2004 surveys found an association ($p < 0.01$) between stress scores and satisfaction with 'overall' working conditions.
- Using linked data from the Wave 1 and Wave 2 surveys, the study found that a significant increase in level of satisfaction with working conditions was predictive of lower stress scores ($p < 0.01$).

Satisfaction with time for family, lifestyle and recreation

- Of recent entrant respondents only 39.1% were either satisfied or very satisfied with time available for family, social and recreational activities.
- As in 2002, both 2004 surveys found an association between stress scores and satisfaction with time for family and social activities ($p < 0.01$).
- Using linked data from the Wave 1 and Wave 2 surveys, the study found that a significant increase in level of satisfaction with time for family and social activities was predictive of lower stress scores ($p < 0.01$).

Workforce attrition and retention

- The findings from both 2004 surveys (using career status and short-term plans) suggest that among postgraduate doctors at this stage of their career:
 - participation in the workforce (Australian and overseas) is between 90% and 95%;
 - attrition is around 0.5% to 2.5% per year (this includes leaving medicine altogether and permanently migrating overseas);
 - at any given point in time 6-19% of postgraduate doctors can be expected to be taking a break with the intention of returning to the workforce (twice as many women as men); and
 - 10-20% can be expected to be overseas with the intention of returning to the Australian workforce. (These findings are similar to Lambert et al (2003) who reported that of 5,702 United Kingdom medical graduates from 1999 and 2000, '10.3% "definitely" or "probably" did not intend to practise medicine in the United Kingdom for the foreseeable future'. Comparative figures for their 1993 and 1996 cohorts were 9.7% and 9%, respectively).

Conclusions

Choice of discipline

1. Three intrinsic factors (appraisal of own skills/aptitudes, interest in helping people and intellectual content of the specialty) are the most influential factors in choice of specialty.
2. Influential extrinsic factors are discipline-related work cultures and working conditions. Experience with these factors occurs throughout medical school and the early postgraduate years, and most doctors choose their specialty during these years. It follows that interventions to influence graduates' choice of specialty should target these critical years.
3. When choosing a specialty, women give greater consideration to the likely impact of discipline-related work cultures and working conditions on their personal domestic circumstances than do men.
4. Number of years to complete training, opportunity to work flexible hours and hours of work typical of working in the discipline are of greater importance to postgraduate doctors who choose general practice than those who choose some other specialty.
5. The effects of debt associated with medical education and training on choice of specialty need monitoring in the future given that in 2004 it was found to be starting to have an influence.
6. Some specialties appear to have developed relatively more effective recruitment strategies than others given the early stage in their career at which most trainees in these specialties make their choice (eg more than 70% of responding RACS and RACP-PCHD trainees in both 2002 and 2004 had chosen their specialty by the end of PGY2 compared with an overall average of 58%). Further research is needed into the strategies used by these training programs with a view to assisting programs with recruitment problems.

Rural workforce initiatives

7. The findings of these two surveys support initiatives to increase the number of 1) rural background entrants to medical schools, 2) rural scholarships/cadetships, and 3) rural education and training experiences.

Hours of work

8. The findings of these two AMWAC surveys about a reduction in hours worked, on average, by postgraduate doctors are consistent with findings from other data sets (eg the AIHW Medical labour force survey data). The findings from the AMWAC longitudinal study suggest that doctors who have completed vocational training have greater control over the hours they work than doctors in full-time vocational training.

Vocational training

9. Further research is needed to explore factors influencing variation across specialties in the career progression of doctors in vocational training.
10. Supervision (both education and workplace) is a critical element of trainee satisfaction with vocational training. A lack of adequate supervision is associated with comparatively low levels of satisfaction.
11. Compared with Wave 2 respondents who had completed vocational training, a high proportion (52.3% versus 38.8%) of those still in vocational had high to very high stress scores. Further research is needed to understand more about the factors influencing these scores. It could be that many trainees feel a lack of control over their lives given long work hours combined with uncertainty over exit examination outcomes.

Continuing professional development for recently qualified specialists in rural areas

12. Access to continuing professional development needs to be improved for postgraduate doctors working as qualified specialists (general practitioners and others) in rural areas.

Type of medical work

13. Factors influencing postgraduate doctor decisions about type of medical work need to be monitored in the future given the fairly substantial percentage (12%) of qualified specialists (Wave 2 respondents) who planned to change the type of work they do.

Influence of medical schools on career decisions

14. Further research is needed to explore factors influencing variation:
 - Among specialties in the representation of International Medical Graduates.
 - Across Australian medical schools in the specialties chosen by graduates from the respective schools.
 - Across Australian medical schools and between State/Territory in the proportion of medical graduates moving interstate to undertake vocational training.

Recommendations

The Working Party recommends:

1. An analysis is undertaken to determine the statistical viability of administering a Wave 3 survey involving respondents and non-respondents to the AMWAC 2004 Wave 2 survey of doctors participating in the longitudinal study and if assessed to be statistically viable a Wave 3 survey be undertaken in 2006.

The purpose of the Wave 3 survey is to monitor both the career decisions of postgraduate doctors as they progress in their professional career; and the factors influencing these decisions. Career decisions of particular relevance to workforce planning continue to be those about choice of specialty, hours of work, workforce attrition/retention, workforce participation, type of medical work, and choice of location (State/Territory and geographic).

2. All 2004 survey respondents are sent the 'Key Findings' document together with a covering letter signed by the Chair of AMWAC thanking them for their participation in the study and indicating how the findings arising from the 2002 study have been published and used by governments and the medical profession.
3. That AMWAC continue to work with the Committee of Deans of Australian Medical School's (CDAMS) with a view to promoting links between the Medical Schools Outcomes Database Project (MSOD) and AMWAC data collections to improve understanding of factors influencing the career decisions of undergraduate and postgraduate doctors.

Reference

Lambert TW, Goldacre MJ, Turner G. Career choices of United Kingdom medical graduates of 1999 and 2000: questionnaire surveys. *British Medical Journal* 2003; 326:194-195.

Attachment 1: Response rate analysis

Table 1: Specialty profile: 2002 target population and Wave 1 (2002) and Wave 2 (2004) survey respondents (%)

	2002 Target population*	2002 respondents	2004 respondents
	n=7906	n=4295	n=2817
General practice	17.6	17.6	17.7
Adult medicine	17.0	15.5	15.5
Surgery	17.0	15.8	12.6
Anaesthesia	9.2	11.3	11.5
Emergency medicine	8.2	9.5	9.3
Psychiatry	8.8	8.4	8.4
Paediatrics and child health	5.9	6.4	6.9
Radiology	3.3	3.6	3.9
Pathology	3.0	3.0	3.4
Obstetrics and gynaecology	2.6	3.0	3.3
Ophthalmology	1.1	1.6	1.6
Rehabilitation medicine	1.3	1.4	1.6
Intensive care medicine	2.7	0.6	1.0
Dermatology	0.7	0.8	1.0
Occupational medicine	0.6	0.6	0.9
Public health medicine	0.6	0.7	0.9
Medical administration	0.4	0.4	0.5
Total	100.0	100.0	100.0

*The target population was all doctors in vocational training in September 2002 as per the records of Australian medical colleges.

Table 2: Sex and age profile: 2002 target population and Wave 1 (2002) and Wave 2 (2004) survey respondents

	2002 Target population	Wave 1 respondents	Wave 2 respondents
	n=7906	2002	2004
		n=4295	n=2817
%Male	55.6 ¹	53.5	51.0
%Female	44.4 ¹	46.5	49.0
Average age			
- General practitioners	33.9 ²	33.0	32.7 ³
- Other specialists	32.8 ²	32.4	32.5 ³

Notes: 1. Source: Medical Training Review Panel (2002), Medical Training review Panel Sixth report, Commonwealth Department of Health and Ageing, Canberra; Tables 1, 6 and 9. 2. Source: Australian Institute of Health and Welfare (2004) Medical Labour Force 2002, AIHW, Canberra; Additional Tables (Primary care practitioners; Specialists and specialists-in-training). 3. Average age in 2002.

Table 3: Sex and age profile of recent entrant respondents compared with target population, 2004

	Target population	Respondents
	n=3075	n=1712
%Male	55.3 ¹	49.7
%Female	44.7 ¹	50.3
Average age		
- General practitioners	33.9 ²	34.8
- Other specialists	32.7 ²	32.3

Notes: 1 Source: Medical Training Review Panel (2004), Medical Training review Panel Eighth report, Commonwealth Department of Health and Ageing, Canberra; Tables 1, 7, 8 and 10.

2. Source: Australian Institute of Health and Welfare (2005) Medical Labour Force 2003, AIHW, Canberra; Additional Tables (Primary care practitioners; Specialists and specialists-in-training).

Table 4: Specialty profile of responding recent entrants to vocational training compared with the target population, 2004 (%)

	2004 Target population* n=3046	2004 respondents n=1712
General practice	29.4	31.5
Adult medicine	11.5	10.8
Surgery	10.4	9.8
Anaesthesia	6.4	6.7
Emergency medicine	8.7	9.0
Psychiatry	6.5	5.9
Paediatrics and child health	2.4	2.8
Radiology	4.1	5.0
Pathology	4.2	4.1
Obstetrics and gynaecology	2.9	3.7
Ophthalmology	1.6	2.3
Rehabilitation medicine	1.1	1.0
Intensive care medicine	4.4	2.9
Dermatology	1.1	1.5
Occupational medicine	1.0	1.0
Public health medicine	1.4	1.5
Medical administration	1.3	1.0
Total	100.0	100.0

*The target population was all doctors who had commenced vocational training since 1 October 2002 as per the records of Australian medical colleges.

Attachment 2: Background characteristics, career status and specialty profile of Wave 2 respondents and respondents to the survey of recent entrants to vocational training

Table 5: Background characteristics of Wave 2 respondents and respondents to the survey of recent entrants to vocational training, 2004

Background characteristics	Wave 2 survey (n=2817)	Recent entrants (n=1724)
• Average age (in 2004)	34.5	33.1
% Male	51.0	49.7
% Female	49.0	50.3
% Married/partnered	76.1	64.8
% Dependent children	83.7	29.6
% International Medical Graduates	13.2	21.9
% Debt greater than \$10,000	18.5	46.1
% Rural background	24.2	21.2
% GPs rural background	28.7	22.1
% Rural Scholarship/Cadetship	4.4	12.2

Table 6: Career status profile of Wave 2 respondents and respondents to the survey of recent entrants to vocational training, 2004

Career status	Wave 2 survey (n=2817)	Recent entrants (n=1724)
% Completed training/practising	33.0	-
% Completed training/taking a break	2.1	-
% In vocational training/practising	59.0	96.0
% In vocational training/taking a break	3.9	3.6
% Left training without completing	1.4	-
% Left medicine altogether	0.6	0.4
Total	100.0	100.0

Table 7: Specialty profile of Wave 2 respondents and respondents to the survey of recent entrants to vocational training, 2004

	Wave 2 survey (n=2817)	Recent entrants (n=1724)
General practice	17.7	31.5
Adult medicine	15.5	9.8
Surgery	12.6	10.8
Anaesthesia	11.5	6.7
Emergency medicine	9.3	9.0
Psychiatry	8.4	5.9
Paediatrics and child health	6.9	2.8
Radiology	3.9	5.0
Pathology	3.4	4.1
Obstetrics and gynaecology	3.3	3.7
Ophthalmology	1.6	2.3
Rehabilitation medicine	1.6	1.0
Intensive care medicine	1.0	2.9
Dermatology	1.0	1.1
Occupational medicine	0.9	1.0
Public health medicine	0.9	1.5
Medical administration	0.5	1.0
Total	100.0	100.0