political view (right wing, middle of the road or left wing) and medical philosophy — the last being a contrast between a technological, science-based approach to medicine and a humanistic approach stressing personal and social factors (this was measured by four Likert-type items).

All students in their first- and final-clinical years received a questionnaire early in 1981 — 40% returned them. Of those who responded 52% were in their first clinical year and 64% were male. Overall, 30% of the students regarded themselves as right wing, 45% as middle of the road and 22% as left wing (3% did not reply).

Table 1 summarizes the characteristics of the sample by specialty of first choice. The distribution of specialties varies significantly between first- and final-year students, the main change being that the proportion of 'undecided' students falls from 46% to 20%. The most dramatic increase in popularity is for general practice; surgery and psychiatry show a reduction in popularity.

Political view, medical philosophy and sex also vary between specialties. All these differences are significant at $P < 0.001$, using the chi-square test for categorical data and analysis of variance for ordinal scales.

Political view. Surgery and pathology are favoured by right wingers — seven out of every 10 would-be surgeons classified their own views as right wing. Psychiatry and obstetrics and gynaecology attract students who are furthest to the political left, with only 16% of right wingers. General practice and the other specialties attract those students who are more middle of the road.

Medical philosophy. Some specialties attract students with a more technological approach — predictably perhaps surgery and pathology and maybe less predictably paediatrics. A more humanistic approach is favoured by those who opt for psychiatry, obstetrics and gynaecology and general practice.

Sex. The overall proportion of men in the study is 64%, but the percentage of men opting for each specialty varies widely. The most popular specialties with men are orthopaedics, surgery and general medicine; women tend to select paediatrics, obstetrics and gynaecology, general practice and pathology.

Several of the variables associated with choice of specialty are themselves correlated with each other (for example, political view and medical philosophy) which gives rise to the possibility that controlling for some variables may eliminate the effect of others. This was examined by further multivariate analysis. It was found that though partially linked, political views, medical philosophy and sex are individually and substantially related to vocational preference. The potential implications of this to the selection of medical students are intriguing.

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Table 1. Characteristics of students by specialty of first choice.

Specialty of first choice	Total number of students selecting specialty as first choice	Ratio of final year to first year students	Percentage of total sample	Percentage of women in the sample	Mean score for political view[a] (range 1–3)	Mean score for medical philosophy[b] (range 4–20)
General practice	111	2.82:1	*22*	*51*	1.9	9.1
General medicine	78	1.34:1	*16*	*18*	1.8	10.3
General surgery	33	0.71:1	*7*	*18*	1.4	11.5
Obstetrics and gynaecology	17	1.56:1	*3*	*53*	2.2	8.1
Orthopaedics	9	1.37:1	*2*	*11*	1.8	9.7
Pathology	6	2.18:1	*1*	*50*	1.5	12.5
Paediatrics	33	1.03:1	*7*	*55*	2.1	10.9
Psychiatry	14	0.82:1	*3*	*29*	2.2	8.1
Other	29	0.89:1	*6*	*28*	2.1	9.2
Undecided	168	0.43:1	*33*	*35*	2.0	9.8

[a]High score = left wing, low score = right wing. [b]High score = technological approach, low score = humanistic approach.

Specialist qualifications

Sir,

General practice is now an established specialty and no longer looked on as the home of those doctors who are failed specialists. It has its own training, its own College, and its own specialist qualifications. General practitioners are now as well qualified in their own specialty as are hospital specialists in theirs.

In consequence I feel that the time has come to recommend that general practitioners use their additional qualifications more freely than they do at the moment, appending them after their names in letters written to their hospital colleagues and to other doctors or addressees where the specialist qualification in general practice is pertinent to the subject under correspondence. It is, after all, logical for a general practitioner to write a referral letter to his medical colleague giving his specialist qualifications in the same manner that the medical colleague will reply to him with MRCP or a similar qualification appended to his own name in order to demonstrate his own expertise.

I know that a number of general practitioners do append their specialist qualifications and indeed my own practice use this style in their referral letters. I hope I can persuade more of my colleagues to do the same, and so increase the dignity of our specialty.

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Part-time posts in general practice

Sir,

I am a vocationally trained general practitioner looking for a permanent post. I am also single and female. I recently applied for a part-time post and understand that I was not considered for interview because of an instruction from the local medical committee that women without family commitments will not be considered for such posts.

My concern and anger at this revelation is twofold. First, I am only too aware how difficult it is for women to gain a full-time partnership in general practice, and had reconciled myself to part-time general practice with limited commitment to another branch of medicine. I now discover this is not possible. Secondly, it seems regrettable that practices will not take up the opportunity to interview likely candidates because of a discriminatory ruling by the local medical committee.

Rarely have I felt moved to put pen to paper on such matters, but on this occasion I felt it was necessary.

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