

Which Primary Care Specialty? Factors that Relate to a Choice of Family Medicine, Internal Medicine, Combined Internal Medicine-Pediatrics, or Pediatrics

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Background and Objectives: *This study was conducted to examine factors used by medical students to select a primary care specialty that may differentiate students who choose the primary care specialties of family medicine, internal medicine, pediatrics, and combined internal medicine-pediatrics. **Methods:** A questionnaire was sent to all family physicians and an equal number of other primary care physicians graduating from one of 24 medical schools in 1997–1999. Twelve schools had increasing proportions of graduates choosing family medicine in this study period, and 12 had decreasing proportions. The questionnaire asked about factors related to choice of specialty, which could be grouped into the specialty domains of type of patients, process, content, and setting. **Results:** For family physicians, the most important factor was patient relationships, and the second most important was wanting an approach to the practice of medicine similar to that of family physicians. Internists indicated as most important wanting to work with adults and as the next most important an “internal medicine approach” to the practice of medicine. Most important for pediatricians was working with children and next most important was having patient relationships like other pediatricians. Those in combined internal medicine-pediatrics most often indicated a desire to work with children and next most important was an approach to medicine like others in their specialty. **Conclusions:** The most important reasons for choice of specialty were similar for all primary care specialties and related to congruence between the graduate and the physicians in the specialty or the process of providing care within that specialty. The factors that differentiated the four specialties related to the content of the specialty.*

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Concern over the supply of generalist physicians is more than 2 decades old.¹ In the past 20 years, attention has been focused on how to address the need for more generalist physicians, both to provide health care for the nation's rural population² and to meet the need for physicians who function as the entry point to the medical care system.

Much of this attention has been directed at the nation's medical schools to determine what can be done to increase their output of generalist physicians. In the early 1990s, it appeared that efforts by medical schools were having an effect on the numbers going into family medicine, because during this time the proportion

of US medical school graduates selecting family medicine increased every year, reaching 17.3 in 1997. However, beginning in 1998, there has been a decline in each year, with just 10.5% selecting family medicine in 2002,³ and 9.2% in the 2003 Match.⁴

As a result of the interest in finding ways to increase the numbers of generalist physicians, a substantial body of research on specialty choice has developed.⁵ Little is known, however, about the process that students use to make decisions on specialty, and most of the studies on decision making have not used a conceptual framework within which the process can be viewed.⁶

Two published studies addressing the process of decision making during medical school do provide a useful framework for interpreting the literature. Burak and colleagues have suggested that the process of choice is “. . . an attempt to project one's self into the realities of a possible career.”^{7,p.535} Burak et al suggest that the fit involves two specialty domains, one being the physi-

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cians practicing in a particular specialty and the other content of the specialty.⁷ Senf et al have viewed the process as an effort on the part of the students to clarify how their values, both those that existed prior to medical school and those that develop during medical school, fit with characteristics and content of the various medical specialties.⁸ Both these views can be combined to provide a framework for understanding the specialty choice “task” that must be addressed by students during their medical school education.

In addition to the specialty domains suggested by Burak, there are two others that likely are of importance. The first is the process of providing care within a specialty—that is, the way in which the physicians in that specialty address content. As an example, the process in surgery is “find the problem and fix it,” while in family medicine it is based more in the relationship with the patient. The other domain is suggested by the literature, ie, the practice types and locations that are characteristic of or available to a particular specialty.⁹

Research indicates that faculty role models are also related to choice of a specialty.¹⁰ Faculty role models provide considerable information to students, often about all four domains. Faculty role models can function in a negative capacity, and the literature suggests that this function is more powerful than the influence of a positive role model.¹¹ This is in part due to the possibility that even a positive experience with a particular specialty may still provide the student with information about one or more domains that is inconsistent with the values important to the student.

Most research has examined students’ choice of primary care versus non-primary care concerns. There have been few studies, however, that compare career choices within the primary care specialties and none that examine factors drawn from the domains described above.¹²⁻¹⁵ The present study is designed to examine factors graduates said were related to their choice of the four primary care specialties of family medicine, internal medicine, internal medicine-pediatrics combined (IM-Peds), and pediatrics, in the context of the declining interest in family medicine and other primary care specialties in the last 5 years.

Methods

Subjects

Using data collected annually by the American Academy of Family Physicians (AAFP),¹⁶ 24 US medical schools were selected, 12 of which had an increase and 12 of which had a decrease in graduates selecting family medicine residencies from 1997 to 1999. These schools were selected to maximize the potential difference in factors related to specialty choice, and Puerto Rican schools were excluded. Figure 1 indicates how the sample was selected.

The 24 schools selected had a total of 1,428 graduates who entered family medicine during the time period 1997–1999, inclusive. These family medicine graduates, all of the graduates who selected combined internal medicine-pediatrics, and a randomly selected, equal number of graduates who entered the primary care specialties of internal medicine and pediatrics were included in the study.

Instrument

A questionnaire was constructed that included items on personal demographics, current specialty, the timing and process of deciding on a specialty, significant medical school experiences, the climate for primary care at the school, including negative comments, mentoring experiences, future practice plans, and attitudes about specific factors related to the graduates’ choice of a specialty. The latter question included items that could be categorized in each of the four specialty domains, ie, people (1), content (5), process (2), and location (4). Graduates were also asked which of these factors were the most and second most important in their choice of a specialty and scored these items on a five-point Likert scale. These questions are included in Appendix A.

Survey Procedures

The questionnaire was pretested on family medicine residents at the University of Arizona. The questionnaire was then mailed to all graduates in the sample. Up to four mailings were used. The first mailing included the questionnaire, the second was a reminder postcard, the third included a replacement questionnaire, and the fourth was another postcard reminder with an e-mail address to use to request another questionnaire.

Data Analysis

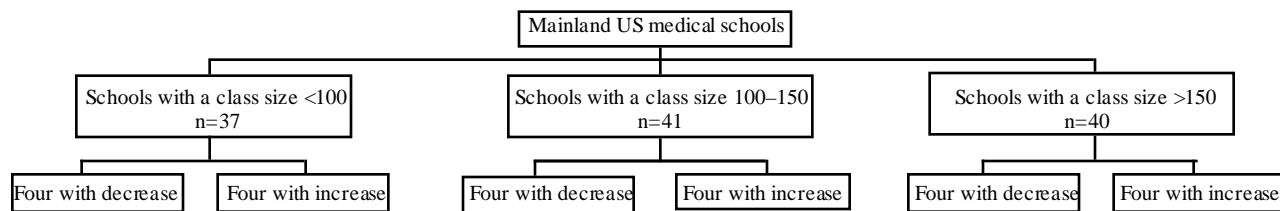
Statistical analyses included chi-square analysis for categorical variables and comparison of means (*t* test) for continuous variables. Five forward stepwise logistic regressions were done to compare family medicine with each of the other primary care specialties and then with all of them combined. Thus, the dependent measure for the first model was students in family medicine versus students in internal medicine, the second was family medicine versus pediatrics, and so forth. All analyses were performed using SPSS for Windows[®] Version 10 or Version 11.

Results

Respondents

The response rate was 51.5%, with 2,985 questionnaires mailed, 155 returned as undeliverable, and 1,457 completed and returned. The response rate by school ranged from 33%–73%. The response rate by specialty was family medicine 57.6%, IM-Peds 56.3%, pediatrics 50.4%, and internal medicine 38.3% ($P < .001$).

Figure 1
Sample Selection



The mean age of respondents was 31.8 years and of nonrespondents was 31.3 years ($P=.002$). Graduates who were members of ethnic minority groups were less likely to respond than white non-Hispanic graduates (41% versus 55%, $P<.001$). The difference between respondents and nonrespondents by gender or year of graduation was not significant ($P<.05$). None of the factors reported here were related to schools with an increase or schools with a decrease in the percentage of graduates entering family medicine, so for all the analyses that follow, all schools were combined.

Table 1 presents the demographic characteristics of respondents by specialty in which each row represents a separate chi-square analysis significant at $P\leq.01$. The proportion of women in pediatrics is higher than in the other primary care specialties, and the proportion of single graduates is lower in family medicine than in the other primary care specialties. The proportion of whites is higher, and the proportion of Asians is lower in family medicine than in the other primary care specialties. Finally, a larger proportion of those in family medicine grew up in a medium-sized city, smaller town, or rural area.

Factor Analysis

Factor analysis to confirm the hypothesized domains (excluding the item about subspecializing, which did not relate to any of the domains) identified four factors with an eigenvalue of more than one, accounting for 66% of the total variance. The analysis did not support the distinction between people and process.

Two content dimensions emerged from the factor analysis, one related to the age group of the patients and one related to activities (which also included interest in international setting). The latter seems to be viewed less as a setting than as a type of practice or specific activity within a practice, because it loaded with other “activities.” A fourth factor included items related to urban/rural location. The items in Table 2 reflect these four factors.

Statements Related to Specialty Decision

There were significant differences (all $P\leq.001$) in the issues that graduates agreed were related to their spe-

Table 1
Current Specialty by Demographic Characteristics*

	Family Medicine	Internal Medicine	Combined Internal Medicine- Pediatrics	Pediatrics
Female	47%	49%	50%	62%
Never married	20%	32%	38%	32%
Ethnicity				
White	75%	65%	65%	69%
African American	8%	7%	6%	12%
Asian	7%	18%	20%	10%
Hispanic	5%	6%	5%	7%
Size of place spent most of time growing up				
Large metropolitan area or its suburb	30%	49%	43%	49%
Small metropolitan area or its suburb	17%	19%	15%	18%
Medium-sized city	22%	15%	19%	16%
Small town	26%	14%	19%	17%
Rural area/farm/reservation/town	5%	2%	4%	1%

* Differences within rows significant at $P<.01$.

Table 2
Current Specialty by Mean Agreement with Statements Related to Specialty Decision*

	FM†	IM‡	IM-PEDS§	Pediatrics¶
People				
My values are like physicians in my specialty.	1.74 ^a	1.98	1.74	1.55
My approach to medicine is like physicians in my specialty.	1.82 ^b	1.92	1.67	1.64
My patient relationships are like physicians in my specialty.	1.75 ^c	2.10	1.72	1.60
Content: patient group				
I prefer to work with children.	2.37 ^d	4.56	1.69	1.02
I prefer to work with adults.	2.25 ^d	1.29	1.85	4.59
Content: activities				
I want to do obstetrics.	3.33 ^d	4.80	4.85	4.76
I want to do surgical procedures.	2.37 ^d	3.92	3.92	3.99
I want behavioral sciences in my practice.	2.37 ^d	3.09	3.12	2.87
I want to practice in international settings	3.51 ^b	3.69	3.35	3.83
Setting				
I want to practice in rural/small-town settings.	2.83 ^d	3.74	3.44	3.69
I want to practice in inner-city settings.	3.88 ^d	3.53	3.36	3.35
I want to practice in urban/large-city settings.	3.19 ^d	2.13	2.50	2.35
I want to/am going to subspecialize	3.88 ^d	2.87	3.19	3.45

* Measured with 1=strongly agree and 5=strongly disagree.

† n ranges from 765 to 772, ‡ n ranges from 235 to 238, § n ranges from 103 to 106, ¶ n ranges from 215 to 217

FM—family medicine, IM—internal medicine, IM-PEDS—internal medicine-pediatrics

a Difference between family medicine and internal medicine and family medicine and pediatrics significant at $P \leq 0.01$.

b Difference between family medicine and pediatrics significant at $P \leq 0.01$.

c Difference between family medicine and internal medicine significant at $P \leq 0.01$.

d Difference between family medicine and all other specialties significant at $P \leq 0.01$.

cialty decision. Table 2 gives the means for each specialty. Items have been grouped into those relating to (1) type of people and process in the specialty, (2) content of the specialty (patient group), (3) content (activities), and (4) settings.

For all specialties, there is strong agreement that there is a good match between themselves and the physicians in their specialty. However, there is a different pattern for the top two choices for each specialty.

For those in family medicine, it is values (type of people in the specialty) and patient relationships (process) that are most important. Those in family medicine least agree that they want to practice in inner city or international settings.

Those in internal medicine most agree that they want to work with adults (content) and that their approach to medicine is like an internist, and their two lowest scores are interest in obstetrics and preferring to work with children, also content items.

For the pediatricians, there is most agreement with wanting to work with children and having values like those in their specialty; they least agree that they want to work with adults or, like the internists, do obstetrics.

Those in internal medicine/pediatrics most agree that they want to work with children and that their approach is like physicians in their specialty. They disagree that they want to do obstetrics or surgical procedures.

As a group, the pediatricians most strongly agreed with all of the items related to being like people in their specialty, while the family physicians most strongly agreed with the three of the four content items (excluding the item about international settings), including that they want to do behavioral sciences in their practice. Family physicians are the most likely to plan a rural practice, and the internists are most likely to plan an urban practice.

Role Models

Having a role model in their specialty was related to how strongly graduates perceived consistency between themselves and the physicians in their chosen specialty, both the type of people and the process of providing care. Table 3 presents the data for graduates with and without a role model. In addition to the statements displayed in Table 3, for those in family medicine who had a role model, there was stronger agreement that

Table 3
Specialty by Role Model in Medical School
and Perception of Congruence

	<i>My Values Are Like Physicians in My Specialty*</i>	<i>My Approach to Medicine Is Like Physicians in My Specialty*</i>	<i>My Patient Relationships Are Like Physicians in My Specialty*</i>
<i>Had a Role Model</i>			
<i>Family medicine†</i>			
Yes	1.6	1.7	1.6
No	1.9	2.0	1.9
<i>Internal medicine‡</i>			
Yes	1.9	1.8	2.0
No	2.1	2.1	2.3
<i>Internal medicine-pediatrics§</i>			
Yes	1.6	1.4	1.5
No	1.9	1.9	2.0
<i>Pediatrics¶</i>			
Yes	1.5	1.5	1.5
No	1.7	1.8	1.8

* Measured with 1=strongly agree and 5=strongly disagree

† Difference between those with and without a role model significant at $P < .001$.

‡ Difference between those with and without a role model significant at $P \leq .05$.

§ Difference between those with and without a role model significant at $P \leq .02$.

¶ Difference between those with and without a role model significant at $P \leq .005$.

they wanted to perform deliveries (3.2 versus 3.5 for those without a role model, $P = .01$), that they prefer to work with children (2.3 versus 2.5 for those without a role model, $P = .002$), that they want to practice in a rural or small town (2.7 versus 3.1 for those without a role model, $P < .001$), and that they want to practice in an inner-city setting (3.8 versus 4.0 for those without a role model, $P = .01$). Graduates in internal medicine who had a role model were more likely to agree that they wanted behavioral sciences in their practice (2.9 versus 3.4 for those without a role model, $P = .004$). Graduates in pediatrics with a role model were slightly more likely to agree that they want to work with children (1.0 versus 1.1 for those without a role model, $P = .03$). There were no additional differences for those in internal medicine/pediatrics. Role models seemed to influence more areas for those in family medicine than for graduates in the other specialties.

Stated Reasons for Specialty Selection

The results on the most important reasons for choice of specialty are very similar but not identical to those presented in Table 2. Results reported here combine the first and second most important reasons listed. Family physicians stated that the most important reason for selecting their specialty was patient relationships (50%

indicated this as one of their two choices) and the second most important reason was a similar approach to medicine (38%). Internists indicated as most important that they want to work with adults (50%) and as the next most important that their approach is similar to others in their specialty (45%). Most important for pediatricians was working with children (93%) and next most important was patient relationships (35%). Those in combined internal medicine/pediatrics most often selected a desire to work with children (52%) and next most important was an approach to medicine like others in their specialty (34%).

The results of logistic regressions are presented in Table 4. The initial model included the attitude items as well as the demographic variables presented in Table 1. The variables presented in Table 4 are those that entered the equation. An odds ratio of less than one indicates that agreement with the statement decreases the likelihood of a graduate being in family medicine and an odds ratio of greater than one increases the likelihood of the graduate being in family medicine.

Discussion

The results of this study indicate distinctly different patterns of factors that are related to the choice of a particular primary care specialty. As categories, the "people" and "process" were consistently indicated to be most important, both in terms of the strength of agreement with the statements and in the factors graduates indicated to be the most important in their choice of their specialty. It is noteworthy that in this study the people and process factors did not distinguish among the specialties because they are important to all of them, although the "values" and "approach" that are being described may or may not be different for each specialty. There is nothing in the literature that would suggest what these perceived differences might be, especially for the question of physician values. Students might be referring to personality type, but the research on personality and the choice of specialty has not found large or consistent differences in the personalities of physicians selecting different specialties.^{17,18} Research on role models suggests that students describe role models as having positive attitudes toward residents and students, enthusiasm about their work, and good communication skills,¹⁵ but this study did not differentiate role models from different specialties. The area of

Table 4
Logistic Regressions Predicting Specialty Choice*

	IM Versus FM OR (95% CI)†	Pediatrics Versus FM OR (95% CI)†	IM-Peds Versus FM OR (95% CI)†	Other Primary Care Versus FM OR (95% CI)†
Type of people				
My values are like physicians in my specialty.	—	—	—	—
Process				
My approach to medicine is like physicians in my specialty.	—	—	—	.68 (.47–.98)
My patient relationships are like physicians in my specialty.	—	—	—	1.8 (1.3–2.6)
Content				
I want to do obstetrics.	—	2.0 (1.2–3.5)	3.1 (1.9–5.1)	2.3 (1.9–2.8)
I want to do surgical procedures.	2.8 (2.1–3.8)	3.1 (1.7–5.8)	2.5 (1.9–3.3)	2.5 (2.2–3.0)
I prefer to work with children.	7.0 (4.6–10.6)	—	.3 (.2–.4)	1.2 (1.1–1.5)
I prefer to work with adults.	.2 (.1–.4)	15.6 (6.5–37.4)	—	1.6 (1.4–2.0)
I want behavioral sciences in my practice.	1.6 (1.2–2.1)	3.7 (1.7–8.0)	2.8 (2.0–3.8)	1.8 (1.6–2.2)
I want to/am going to subspecialize	.7 (.5–.9)	—	.5 (.4–.7)	.5 (.5–.6)
Setting				
I want to practice in international settings	—	—	.7 (.6–.9)	—
I want to practice in rural/small-town settings.	—	—	—	.7 (.6–.8)
I want to practice in inner-city settings.	—	.4 (.2–.7)	—	.6 (.6–.8)
I want to practice in urban/large-city settings.	.6 (.4–.8)	—	—	—
Graduates' specialty correctly predicted‡	95% correct (97% FM, 86% IM)	99% correct (99% FM, 97% Pediatrics)	93% correct (98% FM, 62% IM/PEDS)	86% correct (88% FM, 84% other primary care)

IM—internal medicine
FM—family medicine
IM-Peds—internal medicine/pediatrics
OR—odds ratio
CI—confidence interval

* An OR of less than one indicates that agreement with the statement decreases the likelihood of a graduate being in family medicine, and an OR of greater than one increases the likelihood of the graduate being in family medicine. Satisfaction with one's specialty did enter for the comparison of family medicine and combined internal medicine/pediatrics and pediatrics. However only the contribution of the overall variable was significant, producing no ORs, so it has not been listed in this table.

† All reported ORs are significant at $P < .01$.

‡ Percent correctly predicted is the indicator of how well the model fits in a binary logistic regression.

perceived values of physicians in different specialties is a promising area for additional research and because of the lack of prior research might be appropriate for qualitative research as a starting point.

The data on role models from the present study indicate that having a role model is related to students' understanding of the fit between themselves and the specialty they have chosen and that more areas are related to having a role model for graduates in family medicine with a role model than for graduates in other specialties. This finding is consistent with the literature on the importance of role models¹² but suggests that role models may be more important in some specialties than in others.

The differences between family physicians and those in combined internal medicine-pediatrics are smaller than those between family medicine and internal medicine or family medicine and pediatrics. Those differences that exist are found in the family physicians' interest in obstetrics, behavioral sciences, and surgical procedures.

It is the content, in particular the age group of the patients, that most clearly differentiates the four primary care specialties. Not surprisingly, the largest difference between internists and family physicians is that internists don't want to work with children, and the largest difference between pediatricians and family physicians is that pediatricians don't want to work with adults. This finding is not unexpected, but the ranking

of patient age group as the most important factor in the specialty decision of internists and pediatricians does suggest that the specialties of internal medicine and pediatrics may not be competing with family medicine for the same group of students, nor are they likely competing with each other.

On the other hand, family medicine is likely competing with internal medicine-pediatrics for students. The major difference between family medicine and internal medicine-pediatrics is a lack of interest in obstetrics on the part of the latter students, which is not surprising. However, the difference in interest in behavioral sciences and doing procedures does suggest subtle differences in the breadth of practice desired by graduates in these two specialties. It is also worth noting that even the family physicians were on the average likely to disagree slightly that they wanted to perform deliveries, although wanting to perform deliveries was significantly related to practice location, with those in or planning to practice in small towns or rural areas more likely to want deliveries to be part of their practice.

Finally, it is clear that combining graduates in these specialties may obscure important differences among them, leading to inaccurate conclusions about factors that are important predictors.¹⁹ In this analysis, combining internal medicine, pediatrics, and internal medicine-pediatrics produced different significant factors as predictor variables in the logistic regression.

Limitations

There are several limitations to this study. It relies on respondents to recall what happened years earlier in medical school and is subject to recall bias. The study sample was drawn from just 24 medical schools so these findings need to be replicated in a sample of graduates of students from all medical schools. On the other hand, the findings on gender and ethnicity are consistent with prior literature,⁵ suggesting that the sample may be representative of the larger group of medical students.

To understand better the differences between primary care specialties, additional research needs to specify further the experiences that influence graduates to feel that their values are like the physicians in their specialty and, as mentioned above, specifically what those values are.

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Appendix A
Survey Instrument

How strongly do you agree or disagree with the following statements?*

- a. My values are like physicians in my specialty.
- b. My approach to medicine is like physicians in my specialty.
- c. My patient relationships are like physicians in my specialty.
- d. I want to do obstetrics.
- e. I want to do surgical procedures.
- f. I prefer to work with children.
- g. I prefer to work with adults.
- h. I want to apply behavioral sciences in my practice.
- i. I might want to/am going to subspecialize.
- j. I want to practice in international settings.
- k. I want to practice in rural/small-town settings.
- l. I want to practice in inner-city settings.
- m. I want to practice in urban/large-city settings.
- n. Other (Please describe)_____

* Measured with 1=strongly agree and 5=strongly disagree

From the list above, including any "other" you may have indicated, please put the letter of the most and second-most important reason for your choice of specialty. If it is not on the list, please briefly describe it.

Most Important: _____

Next Most Important: _____

Not on the list (Please describe) _____
