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*of the Paris-based Association of Thought on Research and Higher Education.*

LETTERS

# Prescription failing students

In 1994, for the first time, applicants to the Universities and Colleges Application Scheme were allowed eight university applications rather than five. This change, resulting from merging schemes for ex-polytechnics and traditional universities, threatened major administrative problems for medical schools faced with an immediate 60 per cent increase in applicant numbers at each school.

The *1994 UCAS Handbook* states: "Deans of Medical Schools advise that no more than five choices from the possible eight available should be used for medical courses. An applicant unable to gain an offer from five choices would be unlikely to be successful using up a larger number of choices. The remaining choices, if the applicant wishes, can be used for alternative courses without prejudice to their commitment to medicine". The scheme had the advantage that candidates could make three non-medical "insurance" choices in the event of failure to gain admission to medical school. The scheme had two potential problems: some candidates might choose to increase their likelihood of success by putting more than five medical schools on the form; and candidates who put insurance choices might be perceived as being less than totally committed to medicine. An analysis of all 2,666 home applicants including St. Mary's Hospital Medical School on their application for admission this month (about 22 per cent of all United Kingdom home applicants), comparing the 47.5 per cent of applicants who received one or more offers at any medical school (most of which were not at St. Mary's) with those receiving no offers, suggests that the outcome was not as the deans intended.

Of applicants making five choices for medicine, those who made insurance choices were significantly less successful. It is unlikely that candidates who made insurance choices were academically weaker, as in studies of applicants in the 1986 cohort and the 1991 cohort we found that a difference in educational qualifications did not explain the fact that applicants making an insurance claim fared significantly less well.

In all, 7.9 per cent of applicants made more than five applications for medicine. 48 per cent of them also included insurance choices, usually putting six medical and two non-medical choices, and thereby making 20 per cent more medical applications than candidates restricting themselves to the recommended five, compared with whom paradoxically they were significantly more successful. In contrast those who put six or more medical applications without any insurance choices were significantly less successful than those putting five medical choices alone; we think this may be because the violation of the explicit advice is more obvious to selectors than when medical applications are interspersed with insurance choices. A limit of five medical applications assists medical schools in their task, and should be fair to applicants. Given the high rejection rate, applicants should be encouraged to make insurance choices. Some candidates who put more than five applications seem to benefit unfairly.

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I accept the arguments forwarded in favour of applications being made in the light of actual results, which would make the process of applying less of a lottery and less stressful for students, although I am less clear about the finer details of how this may work in practice. There is, however, a group of students, for whom this arrangement would have greater benefit. There are an increasing number of disabled people entering higher education, for whom universities need to make some preparation.

The present application process makes it extremely difficult for such preparations to take place with any certainty, leaving both the student and the university to make many hasty, last minute arrangements at a difficult time of year. Setting up support, making preparations, securing funding and so on, can take a considerable amount of time. The present arrangement is unsatisfactory and a hindrance to both students and institutions, many of whom are making real efforts to "widen participation".

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# Lip service and confusing the male over menstrual cycles

As chief exponent of the "Lip Gloss" theory of symbolic cultural origins (*THES* September 23), let me clarify the argument for Hilary Rose (Letters, *THES*, October 14). The theory works on the premise that the human female has been designed in the course of evolution to confuse males about the true state of fertility. Lip gloss is not a good indicator of fertility; it is one of an array of deceptive and manipulative sexual signals. Hominine females needed to withhold "good" information about moments of fertility — hence concealment of ovulation — to secure greater energetic investment from mates. Menstruation is a good indicator of impending fertility. It would be surprising if Pleistocene hominine males were not interested in picking up cues about who had recently been menstruating. The onus of proof is on anyone who would argue otherwise. My suggestion is that just as ovulation concealment withheld precise information about moments of fertility, cosmetics would scramble information about who had recently been menstruating. Such deceptive sexual signalling by female coalitions constitutes a prototype of ritual and symbolic behaviour.

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