has three optional opportunities of supplementing his retirement income:
- Buying additional benefits under NHSSS.
- Employing his wife and establishing a pension scheme for her.
- A private pension policy based on any earnings that are non-superannuable.

Subject to the expenditure being convenient it is permissible for a doctor to contribute to all three—investment in one does not preclude participation in the others. The only complication of interdependence arises where a doctor opts to forgo tax relief on his contributions to the NHSSS and effects a private pension contract based on his relevant earnings. Not only can this involve a very considerable addition to net expenditure on pension provision but, and this is not always realized, the decision to forgo tax relief on basic NHSSS contributions means that relief on any additional voluntary payments is forfeit as well.

One final point: from a tax viewpoint every doctor should employ his wife. In my view it is equally prudent and highly beneficial, taxwise, to set up a pension scheme for her. Not only will this improve the family retirement income while both husband and wife are alive, but should the husband die first in retirement, the wife's situation is improved in that the part of her income arising from her pension will not be reduced by 50 per cent.

CONTROVERSY

The need to study complementary medicine

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'I don't really like taking drugs if I can help it—do these tablets have any side-effects?' This is just one, of the phrases being heard increasingly by general practitioners. Reports of side-effects of drugs in the national and medical press serve only to highlight one of the deficiencies of conventional medicine. It is not surprising that more patients are turning to alternative medicine as a means of dealing with their health problems. Is it not time that the College responded to the increasing opposition to allopathic medicine being voiced by our patients?

BEFORE becoming a 'fringe' doctor I spent my first years in general practice getting to know my patients and using the skills that I had learned as a trainee. However, it soon became obvious that there were many conditions that I was powerless to influence. These included many of the chronic diseases, the anxiety-depressive states and recurrent upper respiratory tract infections. The list is legion. Was all my training for general practice to be reduced to the repeat prescription—the inevitable antiobiotic; yet another anxiolytic? I could feel the seeds of discontent and disillusionment being sown. I decided to do something about this.

Four years ago I decided to undertake training in acupuncture. This was followed by training in homeopathy, for which I was fortunate enough to be granted prolonged study leave.

A surprising response

The impact on my 3,000 patients was immediate, dramatic and rewarding. Treatments with acupuncture or homeopathy did not cause rashes, stomachs were not upset, and more surprisingly patients would return saying 'I feel a lot better.'

I was, I suppose, in some sense no longer a 'real' doctor. How could I be if I stuck needles into my patients, or gave them those tablets that were all alike and weren't they only made up of sugar and water? Despite all this my patients continued to get better. Surgeries for me were no longer a trial. I could offer something else for those intractable problems. Now I could confidently treat the child with whooping cough, or glandular fever or recurrent coughs and colds, or the patient with an acute back strain, doubled up in severe pain who, after treatment, would walk out of the surgery straight and virtually pain free. All this without drugs. Was it all just a placebo response?

Need for scientific data

The sceptics dismiss these therapies without any first hand knowledge or experience of their use. They point to the lack of scientific data. But how can this be collected unless more doctors are willing to use and put these methods to the test, comparing their effectiveness with conventional methods. Clinical trials cost money; this is usually provided by the pharmaceutical companies who wish to promote their products. Who will provide the funds for trials on the alternative therapies?

Scientific trials, of which the double-blind cross-over is the accepted yard-stick, negate the individual response in disease and eliminate the doctor/patient interaction.

Medicine is not a pure science; it is also an art. Can one conduct double-blind cross-over trials on empathy, care and concern? Balint has highlighted the drug called 'Doctor'. Has this drug been tested in a trial for its effectiveness and the incidence of side-effects?

Knowledge of acupuncture and homeopathy has allowed me a greater choice of therapies. It enables me to treat the range of conditions that does not feature in the textbooks of medicine, but which we as general practitioners see often.

If we are not able to offer our patients the benefits of complementary medicine they usually seek help elsewhere. This unfortunately exposes them to the unqualified and the ruthless and, in some cases, to the dangerous.

Hostility to the orthodox

Prince Charles, President of the British Medical Association, in his address at the 150th anniversary dinner spoke of some of these problems. He opened his speech by saying 'I have often thought that one of the less attractive traits of various professional bodies and institutions is the deeply ingrained

suspicion and outright hostility which can exist towards anything unorthodox'. I believe he was taking about our attitude towards complementary medicine, and I suggest that the College takes a lead and encourages its members to look into the use of complementary medicine as a whole. From this a body of knowledge will be formed and then we shall be able to judge more fairly its place in patient care.

Those members who already practise alternative therapy should lobby the College. To the sceptics I say 'Go and see for yourself!' Visit a medical practitioner who uses one of these forms of therapy. Then have your say, which then at least will be an informed statement, not one based on ignorance and prejudice.

Let us not forget that our primary concern is to the patient; any form of therapy that may help deserves our attention.

FROM CHAPEL HILL

Medical students

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We are delighted to publish the first of a regular series of newsletters from the University of North Carolina at Chapel Hill. Our correspondent is John J. Frey who is Associate Professor in the Department of Family Medicine there. John Frey was educated at North Western University Medical School in Chicago, Illinois and was a 1973 graduate of the University of Miami Family Practice Residency Program. He taught at the University of Massachusetts Medical School from 1973 to 1979 and has been at the University of North Carolina School of Medicine since 1980. He spent six months as an assistant in general practice at the Glyncorrwg Health Centre, West Glamorgan.

MID-MARCH is a time of great anxiety, noise and confusion in and about the Dean of Students' Office at United States medical schools. Within two days, all 12,874 medical students in the United States learn the results of the National Intern and Resident Matching Program—results which decide each student's future, where he/she will live and what career he/she will pursue.

Articles in the British literature about the process of short-listing and selecting general practitioner trainees for the various schemes reveal some similarities in the two systems. While British trainers size up applicants over sherry, United States programs devote, on the average, $1,200 per position filled per year as well as hundreds of faculty hours to interviews, screening applications, reading letters of recommendation and generally arguing with each other, often quite heatedly, about the qualities that are most desirable in the next crop of applicants.[1] Faculties trade 'war stories' about how it was a few years back when the students were more altruistic, or less clean shaven, or more committed or less in debt.

The perfect roulette system?

The entire complicated operation, with its time, money and enormous subjectivity, culminates in a rank-ordered list being submitted to an anonymous office in Philadelphia by each residency program and each medical student in the country. The ranking lists percolate in the big computer (I assume it's big, but nowadays most micros can probably do the job) from the first week in January until mid-March, when the results—'the match'—are sent to each student and program. Finding the perfect ranking system is similar in scope, and basically as achievable, as devising the perfect system for the roulette tables in Las Vegas.

Some schools even invite the faculty to a ceremony of sorts on 16 March to reveal the outcome and, I suppose, to revel in the 'success' of a plum appointment while politely ignoring the student in the back row who has received no appointment, since he or she did not match with any program, (the fate of 8 per cent of students; more likely from bad judgement than from some inherent character flaw). Unmatched students scramble to find open slots over a 48 hour period, using phone calls and faculty contacts to secure a position.

The average student ranks 10-15 residency choices in his/her list. Regionally oriented students keep lists within a two or three state area. More adventurous students rank programs all over the country and, in the space of time it takes to open an envelope, on March 16 know whether they will have to pack their families off to New York, Texas or the West Coast. There is an atmosphere of rolling dice.

Next year's process begins

Two weeks later, the next year's matching process begins. The Dean of Students meets with the upcoming senior students as a group to explain how the process works, handing them a packet of instructions and 'hot tips' gleaned from previous students, and connecting them with a clinical adviser from the specialty which they are considering.

From April through December, this new group of students will be writing biographical sketches, getting advisers to send letters to residency programs (thank God for word processors which can integrate long lists of addresses with a single letter), and planning their fall months to 'cover' the state of California or Pennsylvania, to interview at as many residencies in as short a period of time as possible. It is an expensive process for students and faculty alike.

Final decisions revolve around such vague terms as 'feels right', 'gestalt' and 'ambience', which would be fine if each were a description of a restaurant rather than a community in which an individual will spend the next three to seven years of his or her life and in which, if statistics are to be believed, two-thirds will ultimately begin practice. The