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

JOHN J. FREY
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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

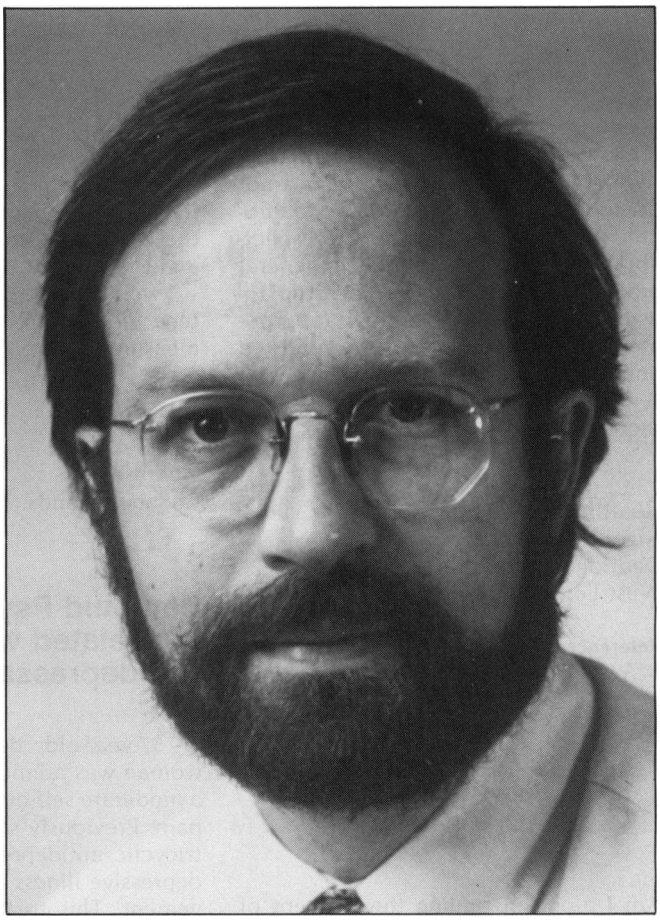
[final] irony lies in the fact that most faculties cannot even recall whether a particular resident was highly ranked in the match or not, once the residency is underway, nor, most studies show, does it make a difference.

Money

The phone rang at my home late one evening revealing the darker side of changes in medical student education in the United States. The caller was a friendly young woman, a first year medical student at the medical school from which I graduated. She and her classmates were phoning all alumni to ask for financial donations for student loans. They had been informed that the student loans on which they had depended were being cancelled. She was faced with raising $14,000 for tuition, room and board or applying to banks for loans at an 18 per cent interest rate. (I recently finished paying my student loan 13 years after graduation, when tuition was $4,000 and the interest on loans was 3¾ per cent.)

The Reagan administration has cut back severely on student loan programs, producing a shift in the type of student choosing to go to medical school. There has been an increase in students from wealthier families and a levelling off, for the first time in years, in the number of black medical students entering. Students are now applying in greater numbers to state schools where tuition fees are very low. For students from poorer families, the choice is not between a state medical school or a private one but between a state medical school or another career.

Recent reports from a conference in New York indicate that students from private and public medical schools are graduating with an average debt of $50,000.[2] Future loans at present interest rates will push expected long-term costs to over $250,000 for many students. Since medical students entering school next year will be entering the job market in the 1990s, the long-term effects of the changes in the attitudes of physicians in the United States are far from clear. A recent poll initiated by the American Medical Association reports that 60 per cent of the American public presently agrees with the statement that physicians are too interested in making money. What attitudes will future physicians, who must make $15,000 a year just to pay off medical school debts, engender in the American public?



Professor John J. Frey.

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1. Bobula JA, Gehlbach SH. A systematic approach to screening applicants. *Fam Med* 1983; **15:** 47-48.
2. Korok M. Medical education: prosperitas interrupta. *JAMA* 1983; **249:** 12-16.

LETTERS

Counselling and the Doctor

Sir,

I read Martin and Mitchell's paper (June *Journal,* p. 366) and your editorial (June *Journal* p. 323) with a strong sense of *déja vu.* Wyld has already produced a comprehensive and critical review of the papers describing the activities of those who counsel in general practice.[1] The paper of Martin and Mitchell adds nothing to what is already known. Similarly, three years ago, you published an editorial entitled 'Is Counselling the Key?'[2] The content of your more recent editorial does not suggest that we are any closer to the answer.

One major barrier to the development of a counselling service in general practice is lack of finance. Some doctors are lucky enough to enjoy the services of attached social workers, clinical psychologists or community psychiatric nurses who, although they vary in their specific skills or emphasis, can be said to have a counselling function. The salaries of these workers are met by local health authorities, or by local government. In the absence of such staff, the general practitioner either will have to rely on members of local voluntary organizations, such as marriage counselling services, or will have to employ his own counsellor. The problem with the former is precisely that they are volunteers and frequently part-time, and cannot therefore allocate much time because of their other commitments. Few general practitioners are likely to be sufficiently strongly motivated to employ their own counsellors and health authorities, for some good reasons, are extremely unlikely to recognize counsellors for 70 per cent reimbursement under the ancillary staff scheme.

What can be done? The College is obviously interested in counselling (why else would the *Journal* publish two editorials on the subject within three years), but does the College have any coherent policy?

There is little convincing data about the outcome of counselling interven-