and antithyroglobulin, to mention just two others, for there is at least evidence to support a pathogenetic role in ophthalmopathy.¹⁻³ In my opinion the data presented do not permit any conclusions to be drawn regarding the pathogenetic agent for either the ophthalmopathy or the dermatopathy.

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¹ Konishi, J, Herman, M M, and Kriss, J P, *Endocrinology*, 1974, **96**, 434.

² Mullin, B R, et al, *Endocrinology*, 1977, **100**, 351.

³ Kriss, J P, and Mehdi, S Q, *Proceedings of the National Academy of Sciences, of the United States of America*, in press.

What shall we teach undergraduates?

SIR,—This was an interesting paper (24 March, p 805) but, while many of the conclusions might have been predicted, we were disappointed not to find in the paper the need to teach undergraduates the problems of the management of the dying patient or terminal care. Much has been learned about this recently¹ but undergraduates still do not receive adequate formal instruction about it. They are often bewildered when the need to treat such patients in hospital or general practice arises. We make a strong plea for this subject to be included in all undergraduate medical curricula.

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¹ Wills, L A M, *Postgraduate Medical Journal*, 1978, **54**, 391.

SIR,—We were interested in the article by Professor V Wright and others on what to teach undergraduates (24 March, p 805) but we cannot agree with their methods or conclusions. To ask a group of people trained in a rigid, didactic system to evaluate it will only tend to perpetuate that system. Moreover, to ask 85 questions of 600 randomly selected practising doctors does not allow for anything but the simple answers requested to these questions; neither could busy persons be expected to devote time and deep thought to add extra comments. Furthermore, the division of whole "specialties" into high and low priorities is spurious.

We do not believe that it is helpful to continue training medical students under a series of headings such as "general medicine," "general surgery," etc. The sooner clinical medicine gets away from a "Big Five" attitude the better patients will be served, as categorisation in this way is an administrative convenience which obscures the true needs of the population. Patients have particular problems such as low back pain, a burn, sepsis, or trying to adjust to the knowledge of their impending death from carcinomatosis. Therefore a topic-based approach to clinical undergraduate training would be more appropriate.

There are a few essential facts (that is, high priority) that an undergraduate has to learn and the identification of these leaves little room for argument. Above and beyond these basics what should be taught could be agreed locally, depending on local needs and on the able teachers available. To this end a league table of teachers, compiled by the students taught and by the "curriculum committee" based on

performance, would identify those capable of furthering student education. We also suggest that recently qualified graduates should be asked about the deficiencies and strengths of the course they followed, in the light of their postgraduate experience of three to four years.

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SIR,—Mr Wasily Sakalo's *Letter from . . . Soweto* (17 March, p 739) recounting his experiences at Baragwanath Hospital, 1978, made interesting reading. I should like to present the most recent developments regarding the question of equal pay for equal work in the medical profession in South Africa.

In 1977 the Minister of Health made it clear that it was government policy to close the wage gap between the races in all work categories (but no undertaking was given that it would in fact be closed). In the mean time, the Medical Association of South Africa continued to press for wage parity, which it had been doing since 1967. It has now been announced in Pretoria that 400 black doctors, mainly specialists, employed by the Department of Health would be paid the same as their white colleagues; and that in the next round of salary increases for doctors wage discrimination would be all but eliminated. The details are not yet available, but it is expected that the increases will be similar to other recent Civil Service increases: 10% for whites, 12.5% for coloureds and Indians, and 15% for blacks. This has been hailed as a major breakthrough and to a large extent it is now anticipated that salary discrimination among full-time professional staff will now disappear.

Without going into the finer details of South African taxation, it should be remembered, however, that in South Africa whites and blacks are so differently taxed that when they are paid the same salary, the black would be better off by far in terms of his net salary after tax. This is due to the Bantu Taxation Act of 1969, which makes no provision for taxing income above R20 129.00 in blacks (while whites earning more than R28 000.00 are taxed 72% for every R1 in excess). Furthermore a married black couple are taxed separately and not jointly as are the whites, which is a highly profitable situation to be in if the wife is in employment. This disparity in taxation is present at all salary levels, and will obviously need to be revised in the not too distant future, when it appears that salaries will, in fact, be equal for all the racial groups. At the moment it appears as though the coloureds and Indians are the worst off, as they are taxed and assessed the same as whites, and yet earn less than them.

I would like to take issue with Mr Sakalo's statement that "the South African government's racist policies are again clear in that the white hospitals have monetary preference over the black . . . and that almost a decade of talks have failed to finalise a new 2000-bed black hospital." Not only has this hospital now been built, but it is attached to a new medical school just outside Pretoria, which will admit black medical students from within and outside the borders of the Republic.

In general, however, his paper is well

balanced as undeniably we do have major problems in health care in South Africa which will take time, energy, and dedication to solve.

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World Medical Association

SIR,—I am mystified at the decision of the BMA Council to recommend withdrawal of the BMA from membership of the World Medical Association at the end of 1979. As a member of the BMA for some 30 years, who retained membership for many years after my own association, the Australian Medical Association, had cut the apron strings, I have always looked on the BMA as a leader in the world of medicine. I repeatedly said as much, and more, in print during the 20 years I was editor of the *Medical Journal of Australia*. I also regarded the BMA as one of the bulwarks of the World Medical Association, on whose council many distinguished members of the BMA have served.

At the 1978 World Medical Assembly in Manila the BMA initiated and carried through a number of resolutions of major importance on a world level. It would have taken a very cynical observer to infer from a reasonable observation of that assembly that the BMA considered the WMA to be other than the important, and indeed indispensable, international medical body that it is.

The Annual Report of Council (*BMJ*, 7 April) conveys a similar impression (p 18) right up to the extraordinary anticlimactic recommendation for withdrawal. The reasons given are an exceedingly vague reference to "objections" to the WMA's new constitution and the desire to save £18 000 per annum. In the same report (p 3) is the official announcement that the Council has awarded the Association's Gold Medal to Mr Walpole Lewin and the recommendation that he be elected a vice-president of the Association. Mr Lewin is the present Chairman of Council of the World Medical Association. He would have to resign that office immediately if the BMA ceased its membership.

The BMA Council's recommendation of withdrawal from the WMA if adopted by the Representative Body would deprive the WMA of a founder member which has contributed (and could go on contributing) invaluable to the cause of medicine and the medical profession in the world. It would also deprive the WMA Council of some of the best chairmen it has had for many a year. The reasons given seem unbelievably flimsy. I hope that the Representative Body will see them to be so.

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The new consultant contract

SIR,—The draft implementation circular has rekindled debate on the new consultant contract. Legalistic in form, it has inevitably given rise to fears and some misconceptions, which were highlighted in the letter from Dr D Hunter Smith and colleagues (31 March, p 895). Their points need answering.

The problem with the present open-ended contract is that it defies definition and therefore has never been and will never be properly