specialty in the immediate future is therefore self-evident in order to maintain an adequate flow of highly trained potential consultant chest physicians, and in order to provide another adequate outlet for junior staff undergoing training in medicine and associated disciplines.—I am, etc.,

GORDON EDWARDS,
Chairman,
Tuberculosis and Diseases of the Chest Group Committee, B.M.A.
Leeds, Yorks.

REFERENCE
[1] Standing Medical Advisory Committee of the Ministry of Health, *The Future of the Chest Services*, 1968. H.M.S.O.

Medicine in Politics

SIR,—Mr. Geoffrey J. Lloyd is to be congratulated upon his forthright letter in which he displays considerable insight (25 January, p. 258). Mr. Lloyd is right to assert that medicine is involved in politics, whether doctors like it or not. Perhaps the instinctive distaste of many doctors for politics arises from an understandable distrust of the professional party politician. Unfortunately such doctors also tend to look askance at colleagues (let alone lay administrators) who are concerned, whether by choice or from necessity, with management and administration. It is as though the medical administrator were suspected of contamination through contact with politicians.

The logical reaction of the mature mind to something or someone it distrusts should be to familiarize itself with what is going on. Only then is one in a position to form an objective and intelligent opinion which commands attention and respect. It is easy to predict that the Special Representative Meeting (*Supplement*, 1 February, p. 31) on the Green Paper[1] will be news by the time this letter appears, and that only a small minority of its most trenchant critics will have bothered to attend their local meetings to brief their representatives. Indeed, many critics will not even be members of the Association, being content to condemn from the touchlines.

May I offer one word of encouragement to Mr. Lloyd? In our teaching in public health, or "community medicine" as Todd[2] would call it, my colleagues and I have been delighted by the interest and concern which our students show in studying and discussing the Green Paper, Seebohm,[3] Todd, and others. They see clearly the far-reaching and profound implications of such proposals for their patients and themselves.

I like to think that undergraduates today are more politically conscious than in the past. They are certainly conditioned less by the prejudices of their elders, myself included, and they are more scientific in their approach to the administration of health services and all that they involve.—I am, etc.,

ALEXANDER W. MACARA.
Bristol, Glos.

REFERENCES
[1] *The Administrative Structure of the Medical and Related Services in England and Wales*, 1968. London, H.M.S.O.
[2] *Royal Commission on Medical Education, 1965–68: Report*, 1968, Cmnd. 3569. London, H.M.S.O.
[3] *Report of the Committee on the Local Authority and Allied Personal Social Services*, 1968, Cmnd. 3703. London, H.M.S.O.

Remuneration of Clinical Teachers

SIR,—Once more the University Grants Committee have defrauded the university clinical staff. Four years ago, the University Grants Committee agreed that clinical responsibility should qualify for the payment of special responsibility pay (almost £400 per year). However, they chose to recommend to the universities that this should be added as two extra increments at the top of the senior lecturer scale, a piece of chicanery which effectively prevented the majority of university clinicians from receiving the money.

Now, by a similar reprehensible method of implementation, they defeat the object of the Prices and Incomes Board recommendation and again the sufferers are a small and relatively powerless segment of the medical profession. We might have expected this in view of our previous experience, but the saddest part is the almost total lack of reaction on the part of the clinical teachers themselves, both locally and nationally. We cannot accept this second iniquitous decision. We must be moved to protest and to fight it. Surely it is easier to make the decision to fight than to decide to uproot and emigrate, which seems to be the only alternative. Indeed, this decision seems designed to cause a tidal wave in the brain drain.

Let us exhort our colleagues: write to the newspapers, the journals, the vice chancellors, your negotiators. Bestir yourselves and join the ginger groups of Association of University Clinical Academic Staff and London University Clinical Academic Staff. There is nothing to lose by action and much to lose by sloth.—We are, etc.,

CLIVE M. TONKS.
W. MCC. ANDERSON.
Department of Psychiatry,
School of Medicine,
University of Leeds.

*** The Secretary writes: The B.M.A.'s university representatives on the Full-time Medical Teachers and Research Workers Committee are co-ordinating activities on behalf of clinical teachers in each university with a medical school, and are arranging meetings, where necessary, to which all clinical teachers are invited.—ED., *B.M.J.*

SIR,—Dr. N. S. Clark and others are right to point out (1 February, p. 319) the grave injustice of the University Grants Committee's proposal on the pay of non-professorial clinical teachers with honorary consultant contracts. However, the immediate injustice is probably greater for honorary consultants of four or five years' seniority than for those who have already reached the top of the present university scale.

Middle-grade honorary consultants would, according to the University Grants Committee's proposal, be placed at the foot of the N.H.S. consultant scale, thus forfeiting their hard-earned seniority. The University Grants Committee's proposal to assimilate senior clinical teachers to the nearest point on the N.H.S. consultant scale will deprive those at the top of the present university scale of £505 per annum, but the honorary consultant of five years' standing will lose £715 per annum (and up to £1,470 when the four "discretionary" increments applicable on the appointment of N.H.S. consultants are also considered). The latest Review Body award[1] when implemented would merely increase the proposed pay deficit by up to £120 a year. All these deficits relate only to basic remuneration. No account has been taken of the very considerable additional payments denied to university staff but received by full-time N.H.S. consultants for domiciliary visits, laboratory tests on private patients, and teaching duties.

All non-professorial teachers who are honorary consultants will wish their official representatives to reject any proposal which deviates from that clearly stated by the National Board for Prices and Incomes.[2] The Board's recommendation—accepted immediately by the Government[3]—was for complete parity of pay between medical teachers with honorary consultant contracts and N.H.S. consultants.—I am, etc.,

S. SELWYN.
Department of Bacteriology,
Westminster Medical School,
London S.W.1.

REFERENCES
[1] *Review Body on Doctors' and Dentists' Remuneration, Tenth Report*, 1969. London, H.M.S.O.
[2] *National Board for Prices and Incomes*, Report No. 98, 1968. London, H.M.S.O.
[3] *Hansard*, 1968, **775**, 416 (written answers).

Points from Letters

Drug Identification

MR. J. SOMERVELL and DR. P. MAYER (Queen Elizabeth Hospital, Birmingham 12) write: We suggest that the name of the drug be clearly written on the dispensing pack, bottle, etc., which is and has been the practice in the United Birmingham Hospitals for nine years. It may, in occasional cases, be undesirable for the patient to know the nature of his prescription. To overcome this, we further suggest that a universally acceptable code system be used. The labelling of prescriptions in either of these ways might well be statutorily enforceable. Further, it would be useful if a pocket compendium noting major drug interactions became freely available to all hospital staff. This could well be a function of the Medicines Commission and be produced as an adjunct to the *British Pharmacopoeia.*

Solvents for Ear Wax

DR. S. L. HENDERSON SMITH (Huddersfield, Yorks) writes: . . . If wax will not come away with gentle but firm syringing a blunt probe is used to loosen the plug from its attachment to the side wall of the auditory canal. Once the water can get a purchase behind the impacted plug the rest is easy. An angled pair of sinus forceps is another invaluable aid. Anyone who has watched the skill of wax-removers on the pavements of India will agree that a little discrete instrumentation under direct vision is worth an ounce of wax solvent.

Iprindole

DR. N. W. IMLAH (All Saints' Hospital, Birmingham) writes: In the Current Practice article on Management of Senile Psychiatric Disorders (7 December 1968, p. 627) there is reference to the problem of side-effects with tricyclical antidepressants, and the suggestion that there is little to choose in this respect.

I consider this not to be the case, and suggest in these cases the use of iprindole, which was not mentioned as an alternative.

Publicity and the Price of Drugs

MR. J. WATSON-FARRAR (Norwich, Norfolk) writes: I have received by today's mail a circular from a very well-known drug company and I am horrified that this circular was posted by first class mail. I have no doubt but that the cost of this postage will be reflected in the cost of this company's products.