Anginal pain in a phantom limb

SIR,—I would like to report an interesting presentation of anginal pain.

A 51-year-old man had an amputation of his left arm after an accident 20 years ago, leaving behind a stump of only about 5 cm. He consulted me for intermittent attacks of paraesthesiae, as if radiating down the left forearm to the thumb and index finger. At first consultation a diagnosis of stump neuroma was made. On subsequent visits he volunteered the information that it was quite a different feeling from the usual deep pain caused by a neuroma and added that it was brought on by exercise. Now his blood pressure was recorded and found to be at a level of 190/110 mm Hg. An electrocardiogram showed features consistent with ischaemic heart disease and a diagnosis of angina was made. The pain was remarkably relieved by glyceryl trinitrate and propranolol.

It is interesting to observe the radiation of anginal pain even in a phantom limb.

C V DEENADAYALAN

Ryton Village,
Tyne and Wear

Pictures in Dublin

SIR,—In his charming review of the recent conjoint meeting in Dublin *Scrutator* (10 July, p 124) claims to have been "looking at half of Hugh Lane's pictures in the National Gallery." I doubt this assertion. While Sir Hugh Lane enriched the National Gallery of Ireland with gifts in his lifetime, *Scrutator* appears to have in mind the contentious Lane Bequest of 39 pictures which have no relationship with the National Gallery of Ireland.

Lane bequeathed this famous collection to Dublin provided that a modern gallery was built. Disagreements arose and in a fit of pique in 1913 he then bequeathed them to the National Gallery in London. In February 1915, before leaving for America, in a codicil to his will he again bequeathed the collection to the City of Dublin. Two months later, on his return journey, Lane was drowned in the *Lusitania*. His signature on the codicil had not been witnessed and consequently the pictures remained in London.

His sole trustee was his aunt, Lady Gregory. Tenaciously and for years she lobbied every name in London from royalty to Lord Curzon, a trustee of the National Gallery in London, for the return of the Lane Bequest to Dublin—"that harassing matter that so often disturbs my sleep." She refused to accept the presumption that Hugh Lane did not believe his codicil to be legal. She died in May 1932, having failed to discharge the duty laid upon her by her nephew.

For many years the Lane Room in the Dublin Municipal Gallery of Modern Art stood open to the public, its walls bare, waiting for the reception of the Lane Bequest. Eventually a compromise was reached: for alternate periods half the pictures would be exhibited at the Tate Gallery in London and half at the Municipal Gallery in Dublin. Today 20 of the pictures are in Dublin and 19 in London. Hence, I suggest, *Scrutator's* reference to "half of Hugh Lane's pictures"—but not at the National Gallery of Ireland.

Recently the Dublin Municipal Gallery has become the Sir Hugh Lane Municipal Gallery of Modern Art and Dublin rumour

has it (and Dublin rumour is rarely wrong) that the entire Lane Bequest is to be restored permanently to that gallery within the next five years. Apart from the joy this unanimous gesture will generate in heaven, nothing could be better calculated to enrich the Anglo-Irish entente cordiale.

JOHN COWELL

Dublin

**Scrutator* writes: "Irish hospitality must have got the better of me (not for the only time that week) and I am glad to acknowledge my error."—Ed, *BMJ*.

Consultant contract

SIR,—I was very interested to read Mr J Kyle's letter (3 July, p 49) on the subject of the consultant contract. I fully support his plea for immediate action and I particularly endorse his remarks about the change in the attitude of consultants, especially over the past 12 months. This tallies perfectly with the general feeling in the Lancashire area, and, I have good reason to believe, in the north of England generally.

On 22 May last (p 1281) you were kind enough to print a letter which I sent in the name of the Blackburn consultants outlining a suggested scheme for a new consultant contract. This letter had been previously circulated to all the chairmen of medical executive committees in the north of England (Cumbria, Northumberland, Merseyside, Lancashire, and Yorkshire) and their comments invited. Your readers will no doubt be interested to hear that I have now received replies from most of them, and they are still coming in. The response has been far in excess of what we had anticipated. There is not a shadow of a doubt that the principles which we outlined have met with tremendous support in this part of the country at least and there is equally no doubt from the tone of the letters about the general feeling of exasperation.

With this in mind I cannot help feeling very concerned (and I am surely not the only one) about the proposed inquiry or questionnaire from the Central Committee for Hospital Medical Services to which Mr Kyle refers. Is this the best that they can devise after 18 months of silence on this subject? I suppose they may well claim that they must find out what the consultants want. Quite apart from the fact that they have had a long time for this particular exercise, I should think that what the consultants want can be summed up in one word—leadership.

The result of yet another questionnaire is predictable. The majority will probably not bother to reply at all. As for those who do, some will want one thing, some another, and we shall end up with yet another set of statistics which will leave us precisely at square one. While this is going on the Hospital Consultants and Specialists Association will be working on the same problem and will send round *their* proposals, which may well be ignored altogether by BMA consultants. This is absolutely deplorable. All consultants belong to the same species whether they subscribe to the BMA or to the HCSA.

Is it really asking too much to suggest that representatives of the two associations should get together and draw up a proposed contract which could meet with the general approval of

consultants and *then* present it *jointly* to the consultant body as a whole? No doubt some will find fault with it. No contract will ever please every single consultant in the land, but surely modifications of some standard contract acceptable to the majority could be negotiated by the minority who, for some reason or another, are unable to fit in with it, with a salary on a pro rata basis.

As for the standard contract, without wishing to imply that the one we proposed is the best possible one, I would at least suggest that one might do worse than adopt it as a basis for building upon. We already know that it has been generally well received in the north. It has the merit of being clear and simple and of linking up with the juniors' contract. The juniors of today are, after all, the seniors of tomorrow and if they are pleased with the contract which they have fought to obtain it is a legitimate inference that they will wish to keep some similar contract when they become consultants.

The present situation, which stems from the loss of status of seniors relative to their juniors, must not be allowed to drag on indefinitely. We are all very much aware of all the strains on the NHS at the moment, thanks to the general economic situation, which affects our work adversely. It is sheer lunacy to add to these difficulties by perpetuating a source of anger and frustration among the consultants who have, up to now at any rate, been looked upon as the leaders of the profession and who are expected to set the standards of hospital practice.

C BRUN
Chairman,
Medical Executive Committee,
Lancashire Area Health Authority,
Blackburn District

Blackburn

Doctors and administrators

SIR,—I must congratulate Mr R J Luck and his colleagues (19 June, p 1534) for bringing to the notice of your readers the absurdity of a situation in which the administrators in the NHS are paid more than full-time consultants. While I do not begrudge some of the key administrators receiving a decent remuneration in keeping with their level of work and responsibility, I do feel distressed at the way our negotiators have allowed the remuneration of highly skilled and well-trained consultants, with a high level of clinical responsibility, to fall behind year after year.

The Rotherham Division of the BMA has been concerned at the way these pay structures have progressed for the two groups in the 25-year period between 1949 and 1974, which members of the profession may not have hitherto appreciated. I give below some information which may be of interest to your readers.

(1) Maximum point of salary scale for a clerk to an executive council of the smallest population group, increased by 429%.

(2) Maximum point of salary scale for a clerk to an executive council in the largest population group, increased by 375%.

(3) Maximum point of the lowest scale for the group secretary of an HMC, increased by 379%.

(4) Maximum point of the highest scale for a group secretary, increased by 377%.

Turning now to hospital medical staff, in the same period the maximum point of the basic consultant's scale increased by only 188%. The relative position of the medical