sick and wounded troops in civilian hospitals, and troops are sent to out-patient clinics for an expert consultant's opinion. This consultation, for which the ordinary fee in private practice is three guineas, costs the Government 6d. For an in-patient soldier the State pays 1s. 6d. per night to be shared among the honorary medical staff. And when all the expert work is done the soldier, quite rightly, will be moved to convalesce in a safer area at the same rate of payment. Moreover, if at any time there are no sick or wounded military sick in the hospital the staff are expected to remain available, but no retaining fee of any kind is paid. Contrast this with the cost of maintaining a fully equipped military base hospital, with a staff of full-time, paid medical officers even if the hospital is empty. The financial saving is so great that any administrative inefficiency can be overlooked. The professional efficiency will depend on those, in any area, generally recognized by their colleagues as being of such merit that in the past they have earned a living as consultants. But how long can the consultants continue to work gratuitously on civilians, for a pittance on soldiers, and to stand by for military emergencies without any recompense? How long, especially in those areas where private practice is dead but where these services are most likely to be needed?

2. My second point is the position of a doctor's dependants if he is killed by enemy action. Contrast the following hypothetical examples; I have made them as extreme as possible to illustrate fully the situation.

(*a*) A surgeon of the highest qualifications and experience attached to a voluntary hospital is killed by a bomb while returning from operating on military wounded in a civil hospital. (*b*) A comparatively recently qualified and inexperienced R.A.M.C. officer attached to a regiment or depot in England, whose work is light and not of a responsible nature, since he sends all difficult cases to hospital, while returning from dancing at a hotel is killed by a bomb. These are extreme examples, but what about the case of the honorary surgeon to a civil hospital whose health breaks down as the result of strain compared with a similar illness in the case of a temporary R.A.M.C. officer? It might be said that the medical profession must stand the same risks as the rest of the population, but this is not a true appreciation of the problem. For I do not know of any other *essential service* of an army carried out by civilians under conditions of great strain and even danger at rates of pay only a fraction of that paid to military officers for similar services and who in addition receive board, lodging, and service. How are dependants of the civil surgeons going to be treated compared with those of the military? I hope that this point is already covered and that our anxieties for those dependent on us are to be mitigated by adequate provision.

I think it will be agreed that these two fundamental points must ultimately gravely affect the efficiency of the professional service available. The spirit is willing but the household expenses high!—I am, etc.,

Hove, June 28. H. J. MCCURRICH, M.S., F.R.C.S.

PS.—Since this letter was written defence areas have been considerably extended and therefore more of the profession are involved.—H. J. McC.

T.A.B. Vaccine in Gonorrhoea

SIR,—Referring to Dr. A. H. Bartley's letter (June 29, p. 1070) on the effects of T.A.B. vaccine in gonorrhoea, I should like to point out its good results in *acute* gonorrhoeal joint disease. When M.O. i/c of a section of Chiseldon Military (V.D.) Hospital in 1919, cases of acute synovitis, chiefly affecting the knee-joint, came under my care. To give a typical case: I saw a patient about 7 p.m. who was very restless and clearly in severe pain, with a tensely swollen and extremely tender knee-joint. Temperature was 104°. After attending to the joint locally I gave him an intravenous injection of one drachm of T.A.B. vaccine—a large dose. On my next morning's visit, about 10.30 a.m., I learnt that he had passed a very restless night with some delirium, that his temperature had risen above 105°, but that now all the swelling, tenderness, and temperature had disappeared and he could flex his knee without any pain or discomfort. He had no recrudescence of his joint trouble. The effect of this treatment seemed really wonderful in these *acute* cases; the treatment is not so effective in chronic ones.—I am, etc.,

Acocks Green, Birmingham, July 1. E. T. LARKAM.

Retropulsion of the Nucleus Pulposus

SIR,—In the *Journal* of November 25, 1939 (p. 1038), I made a plea for more careful consideration of new procedures before their adoption, using laminectomy for retropulsed nucleus pulposus as an example. In a letter which you published on May 18, 1940, Profs. Mixter, Ayer, and Barr attacked this article, accusing me of confusing, in my consideration of their end-results, the cervical cases with the lumbar or "sciatica" cases. The most important and instructive case is, however, a "sciatica" case. This is Case 19 of their first series (Mixter and Barr, 1934, *New Engl. J. Med.*, **211**, 210). Case 19 had pain down the left thigh posteriorly. In spite of a negative lipiodol examination, a lumbo-sacral laminectomy was performed. The unfortunate woman died of a wound infection. This case is referred to in the second paper, but is ignored in the third (that of Barr), reappears in the fourth and fifth papers, but in the sixth paper Barr states: "There have been two deaths in our series: both of these had severe irreparable nerve damage from large ruptured disks" (Barr, *B.M.J.*, 1938, **2**, 1251). There is no mention of wound infection. I feel that I am entitled to ask, Did Prof. Barr forget this case of post-operative death, or has he selected his cases for his end-results? In my article I gave chapter and verse for my statements, and, armed with the relevant articles, you, Sir, and your readers can obtain the truth of the matter in dispute.—I am, etc.,

Hatfield, July 5. SIDNEY PAPPWORTH.

Corrigendum

We regret that owing to a misinterpretation the second reference in the last paragraph of Dr. E. A. Pask's letter in last week's issue (July 6, p. 31) was incorrect. This reference should have been to the article by R. R. Macintosh and F. B. Pratt in *Modern Anaesthetic Practice* (Practitioner Handbook Series), 1938, p. 55.

Obituary

L. G. J. MACKEY, M.D., F.R.C.P.

Physician, Queen Elizabeth Hospital, Birmingham

In the sudden death on June 27 of Dr. Leonard G. J. Mackey Birmingham loses one of its most prominent and popular physicians, who from the outset of his career closely identified himself with the branch of clinical bacteriology in which he deservedly built up a very high reputation for himself all over the Midlands. A student of the Birmingham School of Medicine, he was attached to the staff of the Queen's Hospital and later became its senior physician. During this time he was very largely responsible for the negotiations which resulted in the amalgamation of the two hospitals, the General and the Queen's, into what was then called the United Hospital—a change long needed both in the service of the school and in the service of the city. This change enabled the project of the building of the New Centre Hospital, afterwards named the Queen Elizabeth Hospital, to be proceeded with. Dr. Mackey was a prominent member of the building committee from its initiation, and was intimately associated with the preliminary investigations and subsequent transactions associated with the building. He was one of its first physicians.

Mr. Frank Barnes writes:

A man of untiring energy, an enthusiastic believer in the realm of clinical bacteriology in medicine in which he con-