when it was received and that Council members be asked to comment. Council Agreed.

Council accorded a vote of thanks to Drs. Shapiro and Struthers for their presentation of the Association's case at the conference. 102. Date and Place of Next Meeting of Council: A the suggestion of Dr. Struthers, Council Agreed that the next meeting would take place in Pretoria on 13, 14 and 15 October 1955.

103. Chairmen's Remarks: The Chairman stated that he was grateful to members for their co-operation. He hoped that visitors to the Cape had enjoyed their stay, and on behalf of the Council he moved that a vote of thanks be accorded to the Red Cross Society for the facilities which they had afforded, and to Dr. Purcell and the Civil Service Club for the gesture that had been made regarding honorary membership of the Club for visiting members. He also thanked Dr. Purcell for having made the arrangements with regard to a dinner for members of Federal Council and the S.A. Medical and Dental Council which was to take place that evening. The vote of thanks was Accrued With Acclamation.

104. Thanks to the Chairman: Dr. Radloff moved a vote of thanks to the Chairman for the able way in which he had presided over the meeting. This was Accrued With Acclamation.

The meeting ended at 5.55 p.m.

CONSTITUTION OF THE NATIONAL GENERAL PRACTITIONERS' GROUP

The Steering Committee of the National General Practitioners Group has forwarded for publication the following revised copy of the revised Constitution of the Group as approved by Federal Council at its meeting in October 1954:

I.—Name.

The name of the Group shall be 'The National Group of General Practitioners of the Medical Association of South Africa'.

II.—Objects.

2. The objects for which the Group is established are:

(a) To promote General Practice,
(b) To define and establish relations amongst General Practitioners and all Groups of the Medical Association and between General Practitioners and hospitals, public and private institutions, government authorities, the medical profession generally and the public.
(c) To promote the professional and legitimate interests of General Practitioners.

III.—Membership.

3. Any person who is a registered medical practitioner within the Union of South Africa and who is a member of the Medical Association of South Africa is eligible for membership by virtue of his membership of his branch or section, where such branch or section exists, and providing:

(a) His professional practice is confined to General Practice.
(b) The nature of his practice is such as to give him a special interest in the subject of General Practice.

4. Every member shall remain a member until his membership is terminated either by his resignation in writing addressed to the Honorary Secretary-Treasurer or by decision of the Executive Committee of the Group. His membership may be suspended if after one year he has not paid his due subscription, but he may be reinstated on payment of arrear subscriptions due. During the period of suspension he shall not retain his vote.

5. The activities of the Group shall be suspended if, at any time, its membership shall be less than 11 (eleven) members.

IV.—Control.

6. The general control and direction of the policy and affairs of the Group shall be vested in the National Committee of the Group and its Executive Committee.

7. The National Committee shall be elected by branches or sections, each branch having 1 (one) member for the first 50 (fifty) and thereafter 1 (one) member for every additional 100 (hundred) or the major portion thereof.

(a) The office bearers and Executive shall be elected by the National Committee out of their members and shall consist of a Chairman, two Vice-Chairmen, an Honorary Secretary-Treasurer, and five members of the Executive.

(b) The Executive or any sub-committee of the National Committee may co-opt any member or members of the Group for a special purpose, the co-opted member to be without voting powers.

(c) The National Committee shall meet at least twice a year.

(d) Provision shall be made for proxies with approval of the branches or section.

8. A list of office bearers, together with a complete list of members of the Group shall be furnished annually to the Medical Secretary of the Association within 30 (thirty) days of the election of such office-bearers.

9. The Honorary Secretary-Treasurer of the Group shall keep records of all meetings of the Group and of the Executive Committee and shall conduct all correspondence in connection with the affairs of the Group. He shall receive all monies due to the Group and shall make all disbursements authorized by the Executive Committee.

V.—Meetings.

10. The Annual General Meeting shall be held once a year at or about the time of the Annual General Meeting of the Medical Association. The quorum shall consist of 20 (twenty) members inclusive of proxies.

11. General Meetings of the Group may be held from time to time and shall be called by the Executive Committee on the written request of 40 (forty) members of the Group. Voting by proxy shall follow as nearly as is material the form prescribed in the Bye-Laws of the Association.

VI.—Action.

12. The Group may take such action as may be deemed necessary in all matters affecting the legitimate interests of its members; provided that the Association as a whole be not involved or pledged to any action and that any action contemplated by the Group be in conformity with the policy of the Association for the time being in force.

13. Should the Group refer a matter affecting the interest of its members to the Federal Council of the Association for action, it shall take no further independent action unless requested to do so by Federal Council.

VII.—Organization.

14. Shall consist of the National Group with branches which follow closely on the pattern established in the Medical Association of South Africa. The branches may divide themselves further into sections. Such branches may be allowed powers of independent action in local matters provided that such action is not in conflict with the General Policy and rules of the Group, and of the Association in general.

15. The method of election in each branch shall be left to the discretion of the Executive Committee of the branch or section that each branch shall elect. Such branch or section shall elect a Chairman, an Honorary Secretary-Treasurer, and an Executive Committee consisting of six or more members annually at the Annual General Meeting of the branch or section, which shall be held three months prior to the Annual General Meeting of the Group.

16. Reports of local action taken shall be submitted within 14 (fourteen) days by the Honorary Secretary-Treasurer of the branch or section to the Honorary Secretary-Treasurer of the Group.

17. That each branch or section may draw up their own By-Laws for the conduct of their local affairs including the method of election of delegates to the National Committee. Nothing in these By-Laws shall be in conflict with the Constitution of the National Group.
POSTGRADUATE MEDICAL EDUCATION

The American Medical Association announces that during a recent period of 2½ years its Council on Medical Education and Hospitals has been engaged in a comprehensive survey of postgraduate medical education in the United States. The use of the term postgraduate education has come to be distinguished from graduate medical education as follows:

Graduate education includes relatively long periods of training such as internships, residencies, fellowships and formal academic work, which lead either to specialty status or an advanced academic degree.

Postgraduate education refers to somewhat broader periods of study of perhaps a few days to a few months and which are designed to refresh a practitioner in his own field of practice or extend his knowledge of one particular element of it.

The survey of postgraduate facilities has included field visits to most of the 300 or more institutions and organizations in the USA offering postgraduate courses.

A preliminary report of the findings of the survey was presented at the 50th Annual Congress on Medical Education and Licensure a year ago. Since then, the material collected during the study has been worked up into a final report. This will be published during 1955 as a series of special articles in forthcoming issues of the Journal of the American Medical Association as follows:

26 February—The Scope and Extent of Postgraduate Medical Education in the United States. 12 March—The Physician as a Lifelong Student. 26 March—The Objectives and Content of Postgraduate Medical Education. 9 April—Educational Methods in Postgraduate Teaching. 23 April—Time and Place Arrangements of Postgraduate Courses for Practising Physicians. 7 May—Sponsorship and Administration of Postgraduate Medical Education. 21 May—Financing Postgraduate Medical Education. 4 June—The Future of Postgraduate Medical Education.

After the Journal publication of the last of these articles, the entire series will be reprinted in monograph form, to which will be added a section on the 'History of Postgraduate Medical Education' and a number of appendices containing additional detailed material derived from the survey.

VACCINATION AGAINST PARALYTIC POLIOMYELITIS: PERFORMANCE AND PROSPECTS

ABSTRACT OF A PAPER BY DR. JONAS E. SALK OF THE VIRUS RESEARCH LABORATORY, SCHOOL OF MEDICINE, UNIVERSITY OF PITTSBURG

The paper of which the following is an abstract was presented by Dr. Salk at the conference held at the University of Michigan on 12 April 1955. It was accompanied by many charts illustrating the results of experiments. The paper had been prepared without prior knowledge of Dr. Frances' report on the 1954 Poliomyelitis Vaccine Field Test.

Dr. Salk said that with killed-virus preparations the destruction of infectivity and the reaction of immunological response were governed by definable laws. The destruction of infectivity with formaldehyde proceeds as does a first-order chemical process, and the time required can be predicted rather precisely. In the production of the vaccine the antibody-producing power is not measurably reduced unless over-treatment is extended for a period more than 5 times that required to reduce infectivity to a point at which it is no longer measurable. This is an ample margin of safety. Moreover the vaccine is so stable that no special precautions are required for its maintenance.

The amount of killed-virus polio vaccine required to produce immune response in man is far less than might have been anticipated from comparison with most other microbial antigens; and it is much easier to produce immune response in man than in the monkey, and in the monkey than in the mouse. Moreover the antibody persists much longer in man than in monkey or mouse.

The optimum immunological response to two injections of the killed-virus polio vaccine is obtained in the monkey if they are separated by an interval of 4 weeks. In the mouse the optimum interval is much shorter; in man it is much longer (months rather than weeks). These facts were known before the 1954 Field Test, but there was not time to put them in practice, and the test was therefore of the question whether primary vaccination alone could prevent paralytic poliomyelitis rather than of the effectiveness of full immunization, which could have been achieved only if the course of innoculations had been extended over a number of months at least.

It has been shown that if merthiolate is added to the vaccine to inhibit bacterial or mould contamination its antigenic property steadily declines over a period of months. The effect of merthiolate is more rapid at a higher temperature, effecting almost complete destruction of antigenicity within a few days at 37°C; but under certain circumstances rapid deterioration has been observed even at refrigerator temperatures. The effect is quickest in the type-I component, next for type II, and last for type III. Certain of the vaccine used in the Field Test was merthiolated, and tests of the effects on children of a number of lots of vaccine used in the Field Test have shown substantial reduction of immunizing power in certain lots. This is largely attributed to the merthiolate, but also, perhaps, to variation in the starting material.

It has been shown (1955) that if versene is added to the polio vaccine in addition to 1 : 10,000 merthiolate the destructive effect of the merthiolate is prevented while its antiseptic or preservative qualities are retained. The solution of the merthiolate problem by the addition of versene is the result of the efforts of the Research Staff at Eli Lilly and Company. Other laboratories similarly engaged in vaccine production are solving the preservative problem in a number of ways, either by not using it at all, as is the case at the Connaught Research Laboratories, in Canada, and in certain European laboratories, or by the use of other chemicals that can be shown to exercise the necessary anti-microbial effect without impairing antigenic activity.

As the result of experience polio vaccine is being prepared in 1955 of greater potency than the vaccines used in 1954.

Dr. Salk again emphasized that the 2nd (booster) dose of polio vaccine should not be given until at least 7 months after the 1st dose of vaccine, if the maximum effect is to be obtained.