subnormal and supernormal—as a factor in delinquency." He pointed out that the relation of intelligence to delinquency was indirect, and the intellectual factor had always to be considered in relation to the personality as a whole. Subnormal intelligence itself was a rare cause of crime. Dr. J. D. W. PEARCE gave two lectures on the psychopathology of delinquency, showing how delinquency was a reaction to negative feelings engendered by the frustration of fundamental urges, and how the delinquent gained compensatory satisfactions and escape from difficulty, usually without being aware of what he was doing. He also dealt with delinquency as a symptom of various psychoneuroses, psychoses, and metabolic disorders. On the Sunday Dr. DENIS CARROLL lectured on the medical treatment of delinquents. A general discussion took place on the topics raised in all the lectures.

PREGNANCY AND PARTURITION AFTER AMPUTATION OF THE CERVIX

A meeting of the North of England Obstetrical and Gynaecological Society was held in Leeds on April 29. Dr. J. W. A. HUNTER (Manchester) read a paper on the effect of amputation of the cervix on subsequent pregnancy and labour.

Dr. Hunter made a plea for a more conservative attitude to endocervicitis and cervical lacerations in view of the increasing adoption of extensive plastic procedures in women of child-bearing age in preference to pessary treatment. A study of the literature dealing with the dangerous sequelae of cervical amputation and repair led to the conclusion that these operations in women of child-bearing age might cause sterility, repeated abortion, premature labour, or obstructed labour. His interest indeed was first drawn to the subject by seeing a case under the care of the late Dr. Haig Ferguson. The patient had had her cervix amputated previously by Emmet himself, and subsequently had seven abortions. A first and living child was at last obtained after she consented to remain in bed from the onset of the pregnancy. In the last nine months he had encountered nine further cases of abortions occurring for the first time after cervical amputation. Discussing the question of dystocia, Dr. Hunter went on to describe a series of eighteen cases of labour following cervical operations. In ten the labour was uneventful, in three Caesarean section proved necessary, in three vaginal Caesarean section, and manual dilatation of the cervix was needed in two cases. There were three maternal deaths following delivery by the vaginal route, all being due to a rupture of the cervical stump extending up into the lower uterine segment.

Modified Plastic Operation

In an attempt to minimize the dangers of cervical plastic surgery, Dr. Hunter said he had devised a modification of the usual plastic technique to be used in some cases of prolapse occurring in young women, particularly those cases in which there was little cervical hypertrophy present and the length of the uterus did not exceed three and a half inches—cases in which there was relaxation of all the uterine supports. Essentially the operation consisted of one circular incision about half an inch above the external os, and another one inch to one and a half inches above this, enabling a complete circle of vaginal skin to be removed. The customary anterior colporrhaphy was then performed and completed by first suturing the cervix to the vaginal skin, beginning behind and working round to the front at each side. Thus the Fothergill principle of sliding the uterus upwards and backwards was maintained but with conservation of the cervix. Sometimes after the operation the uterus tended to remain in the vaginal axis. This might be remedied by opening the anterior peritoneal pouch and stitching the uterus to the peritoneum at the level of the anterior colporrhaphy, or alternatively by performing a Gilliam's suspension operation.

Professor DANIEL DOUGAL said he had done a similar operation on one occasion; he advocated only a low amputation in these cases of prolapse in young women. Mr. JEAFFRESON (Leeds) confirmed from his own cases the increased tendency to abortion after cervical amputation. The main technical operative difficulty in dealing with this type of prolapse was that unless something was done to fix the cervix the vaginal walls tended to sag after the operation.

Mr. GLYNN DAVIES (Sheffield) stressed the need for removing the unhealthy tissues surrounding the os uteri; he found that removing but a shaving of the cervix sufficed in performing the Fothergill operation. In an analysis of 400 cases he had found that only 60 per cent. of the women who could have conceived after the operation did so. Mr. BRYAN WILLIAMS (Liverpool) did not consider that cervical repairs had a significantly sterilizing effect, but regarded routine amputation of the cervix as quite unjustifiable in women of child-bearing age. Professor W. FLETCHER SHAW welcomed criticism of the Fothergill operation in view of its widespread adoption. He did not think the operation had a sterilizing effect, rather the reverse; in about one-third of the cases the prolapse recurred after a subsequent labour.

Local News

NEW ZEALAND

[FROM OUR CORRESPONDENT IN WELLINGTON]

When an Insured Person is Not Insured

Whether tetanus, in a case which ended fatally, was an injury received when a woman fell from a motor-car, or whether it was only the result of the injuries, was one of the questions that arose in an interesting case decided by the New Zealand Court of Appeal in judgments delivered on April 29. The appeal was brought by an insurance company against the decision of Judge Northcroft, who held that the administrator of the estate of a deceased woman was entitled to recover from the company the sum of £1,000, being the amount the woman was insured for at the time she fell from a moving car and suffered slight physical injuries from which tetanus developed. Three judges allowed the appeal and one dissented.

The Chief Justice said that the correctness of the decision depended upon the true construction of the insurance policy. The policy provided that the company should pay to the insured or her personal representative:

"(*a*) if the insured shall within three calendar months of the occurrence of the accident die solely as the direct result of the actual physical injuries received in the accident, the sum of £1,000 . . . provided that no compensation shall be payable under Section (*a*) when the death is due to a disease which is the direct or indirect result of the injuries received in the accident, or which may attack the insured in consequence of his lowered vitality, whether such lowered vitality is due to the accident or not, or for death due to a disease from which the insured suffered prior to the accident, and which has been intensified by the accident."

The Chief Justice declared that the disease itself could not be said to be part and parcel of the "actual physical injury" received in the accident. The most that could be said, as the trial judge had found, was that at the time of the accident there was imported into the wound dirt which included germs or spores of tetanus. The case, in his opinion, seemed to be that of a disease "supervening and consequent upon the actual physical injuries." In other words, the insured sustained actual physical injuries, the disease of tetanus supervened as a direct result of such injuries, and the insured died as a result of that disease. Thus the case came within the proviso. He also stated in his judgment as follows:

"There is no reason why an insurance company, if it thinks fit, should not by appropriate exception or proviso exclude liability where the death is due to disease, however that disease may be caused. That is exactly what has been done in this case. If I am right, then, even though there was imported into the wound at the time of the accident dirt which contained germs or spores of tetanus, and such importation can be said to be part and parcel of the actual physical injury, the death of the insured was admittedly due to the disease of tetanus which developed some days after the injury. Such disease was the direct result of the injury—that is, of the importation of the germs or spores into the wound. The company in this case had expressly protected itself against liability where the decease was due to a disease supervening on the injury, and not merely against liability where the decease was due to an intervening disease."

The dissenting Judge held that the language of the exception or proviso in the insurance policy was inappropriate to exclude a disease, such as tetanus in this case, which, arising from the accident, was itself one of the injuries and not merely a result of the injuries. Tetanus was not "the result of the injuries" but was in itself the main injury.

National Health Insurance

A special session of Parliament was called to pass a National Health Insurance and Superannuation Act. However, no such legislation was passed because the Government declared that many difficulties lay in the way and much more consideration of the proposals was required. Therefore a special Parliamentary committee was set up to take evidence in the recess and advise the Government. Before this committee had time to do more than begin its investigations, the Prime Minister announced the Government's policy. There is to be a means test for superannuitants, but none at all for the national health service. The latter service is for all, rich and poor alike; it will provide no specialist treatment. The health and superannuation scheme will add a shilling in the pound to income tax and an unknown sum, in addition, will be drawn from the Consolidated Fund. This will assist the redistribution of wealth.

After the Prime Minister's policy was announced the Parliamentary committee continued to take evidence. Testimony from representatives of the medical profession was not very well received. The views of witnesses representing the Hospital Boards Conference were, in the main, at variance with the Prime Minister's proposals. A representative of the Douglas Credit Group said the whole scheme could be made to cost nothing. At present, therefore, it may be said without fear of contradiction that nobody knows in what precise way national health is to benefit. Facilities for drinking medicine will be increased and the hours extended.

ENGLAND AND WALES

King Edward's Hospital Fund

The Duke of Kent, presiding over the annual meeting of the President and Council of King Edward's Hospital Fund at St. James's Palace, announced the start of the new experiment in co-operation in the voluntary hospital service of London—namely, the establishment jointly by the hospitals and the King's Fund of a central office to facilitate the quicker admission of urgent and acute cases (see *Journal*, June 4, p. 1221, and p. 1325 of this issue). The annual report showed that the hospitals taken together had increased their income in 1937 by about £350,000. Expenditure had also increased, however, and the net result was a small credit margin of about £8,000 on a turnover of over £4,500,000. This was better than in 1936, when there was a small aggregate deficit for the first time since 1926, after which year the aggregate income of the London hospitals had increased from a little over £3,000,000 to well over £4,000,000 and the total receipts for capital and maintenance had grown to £5,000,000, including more than £2,600,000 in voluntary gifts and over £1,000,000 contributed by patients. The Duke of Kent added that this result had not been attained without great personal efforts and sacrifices on the part both of hospital workers and of members of the public, and that still greater efforts would be needed in view of the increasing difficulties of the present time. But they were worth while, for there were great advantages in the system of having two kinds of hospital, the voluntary and the municipal, influencing each other and co-operating to form a complete hospital service, the voluntary hospitals emphasizing the values associated with freedom, elasticity, and personal initiative, so important in medicine and surgery, and the municipal hospitals the values associated with large-scale work and centralized administration under a public authority. The voluntary hospitals were trying to increase their income and on the other hand to combine the advantages of organization with those of freedom by means of voluntary co-operation. The King's Fund had from time to time been able to help the hospitals in their efforts to develop new sources of income. Within the last two years the hospitals had agreed to the inauguration of a combined flag-day, which had succeeded splendidly. It was announced by the Distribution Committee that it now had a stock of seventeen grammes of radium, most of which was out on standing loans to various individual hospitals; a small quantity was kept in a pool, from which it was lent to certain hospitals when it was needed for a patient. Thus, the newer forms of radium treatment could be developed where radium was applied in large quantities at a distance from the patient.

Home Service Ambulances

The nineteenth annual report of the Home Service Ambulance Committee of the Joint Council of the Order of St. John and the British Red Cross Society states that the ambulances carried 161,840 patients during 1937. In the course of the year under review two new stations were equipped, one at Kington in Herefordshire, the other at Ripley in Derbyshire. The report describes the notable increase in comfort, and even luxury, which is a feature of modern ambulances, so that journeys of two hundred miles or more are undertaken without undue distress for the patient. Improvements have also been evolved in methods of loading and unloading stretchers. With regard to the *x*-ray department it is stated that the mobile *x*-ray unit is able to carry out in private houses and nursing homes radiographic work of a quality comparable to that produced by the stationary unit of a large hospital. The service provides both a high-powered unit for ultra-rapid chest radiography and a low-powered set for fine focus maximum detailed investigation of bones and joints. The report stresses the importance of an adequately trained personnel, imbued with sympathy, knowledge, and judgment. Except in times of special emergency the transference of the ambulance work of the country to municipal or national control is not advocated. It is, however, suggested that a fuller recognition of a service which carries a growing burden of public work is desirable on the part of local authorities, especially those responsible for county administration.

Sewage in the Mersey Estuary

In a report issued as Water Pollution Research Technical Paper No. 7 by the Department of Scientific and Industrial Research (H.M. Stationery Office, 30s.) a detailed description is given of the results of a chemical, hydrographical, and biological investigation of the effects of the discharge of crude sewage on the amount and nature of the deposits in the estuary of the River Mersey. For many years the possible effects on the conservancy of the estuary of the direct discharge of sewage from a population of nearly one and a half million people have given rise to controversy among the local interests concerned. Since 1890, to facilitate the passage of ocean-going ships, the sea channels in Liverpool Bay have been deepened by continuous dredging. It had been suggested that the nature

of the material deposited in these channels was so altered by the presence of sewage in the water as to increase the difficulty of dredging. In 1932 the local sanitary authorities and the bodies interested in the navigation of the estuary invited the Department of Scientific and Industrial Research to investigate the effect of the sewage on the amount and hardness of the deposit, and agreed to pay the whole cost of the work. The following year a laboratory was set up in Liverpool and two boats were specially built for the investigation, which occupied four years. The quantities and nature of the sewage and principal trade wastes discharged into the estuary were ascertained, the concentration of polluting substances in the estuary water under different tidal conditions was determined, and an estimate was made of the length of time spent by polluting substances in the estuary before passing out to sea. Laboratory experiments were then made to observe the effect of sewage on the rate of sedimentation of mud and silt under conditions similar to those which occur in the estuary. Numerous samples of mud and other solid matter for examination were taken from different parts of the upper estuary of the Mersey and from Liverpool Bay, and for comparison samples were also collected from relatively unpolluted estuaries and marshes elsewhere. Some 180,000 to 240,000 cubic yards of sewage are daily discharged directly into the estuary, but the concentration of sewage in the greater part of this water does not exceed 1 per cent. by volume, and in no considerable volume of water does it exceed 5 per cent. The quantity of inorganic suspended matter discharged in the sewage in a year is less than 25,000 cubic yards, or 0.0025 per cent. of the capacity of the upper estuary. The concentration of organic matter in mud from the Mersey was found to be approximately the same as that in mud from the bed of the Irish Sea, from Liverpool Bay, and from the relatively unpolluted estuaries examined. Sewage, in the concentration in which it is present in the Mersey, has no appreciable effect on the composition of the intertidal deposits. In direct answer to the terms of reference the report states: "The crude sewage discharged into the estuary of the River Mersey has no appreciable effect on the amount and hardness of the deposits in the estuary." The investigation was not concerned directly with such problems as the effect of sewage on the sanitary condition of the river and foreshores nor on fisheries, but much of the work described, particularly that dealing with the conditions affecting the rate of sedimentation of suspended solids, is also of far wider interest, since sedimentation is an essential process in many methods of treatment of sewage and trade effluents and of water for domestic supply.

International Psychotherapy Congress

The provisional programme has now been issued for the tenth International Medical Congress for Psychotherapy, to be held at Balliol College, Oxford, from Friday, July 29, to Tuesday, August 2, under the presidency of Professor C. G. Jung. Before the Copenhagen meeting last year the congress had taken place in various towns in Germany; this is its first meeting in an English-speaking country. On the Friday evening, after dinner, there will be a reception by His Majesty's Government in Christ Church Hall, the guests being received by the Minister of Health, and on the Monday evening the Mayor of Oxford will give a reception in the Town Hall. The main subjects for discussion at the scientific sessions are: (1) psychology of the phases of life; and (2) psychotherapy and psycho-somatic problems. The languages of the congress are English, German, and French. Synopses of the papers read will be provided in all three languages, and discussions will be interpreted. Members, both men and women, will be accommodated in the students' rooms in Balliol College and in Somerville College. The honorary secretary of the organizing committee in England is Dr. E. B. Strauss. The business secretary is Mr. M. H. Gibbs-Smith, whose office address until July 28 is 106, Brompton Road, London, S.W.3.

SCOTLAND

Glasgow Postgraduate Courses

A summer session for postgraduate teaching has again been arranged under the auspices of the Glasgow Post-Graduate Medical Association. The facilities will fall chiefly into three divisions: (*a*) general medical and surgical course, (*b*) intensive courses, and (*c*) clinical assistantships. During the last two weeks of July and the month of August whole-time courses, for which an inclusive fee is charged, will be conducted in some of the general and special hospitals. The course will include most of the subjects of interest to the general practitioner—the mornings being occupied with general medicine and surgical diagnosis and minor surgery in the Victoria, Western, and Royal Infirmaries, and the afternoons with special subjects in the special hospitals or departments of the general hospitals, two subjects being dealt with each afternoon. In a number of the institutions taking part in the work of the association clinical assistantships are available in the summer months as well as at other times. Full particulars may be had from the secretary, Glasgow Post-Graduate Medical Association, The University, Glasgow.

Long-term Sickness in Scotland

At the annual conference of the Association of Approved Societies, held in the Empire Exhibition, Glasgow, on June 3, Mr. W. S. Douglas, Secretary of the Department of Health for Scotland, said that health in Scotland was not so good as it was in England. The Government had approved the principle of holidays with pay; such holidays would be a tremendous contribution to the health of the nation. Miss Muriel Ritson, Controller of Health and Pensions Insurance, said that the greatest boon conferred upon workers by the National Health and Unemployment Insurance Acts was not to be found in the actual cash benefits but in the sense of security which they gave to the whole mass of the working population. It was a matter for regret that twenty-seven years of national health insurance had not seen a really great diminution in sickness among the insured population. A bad epidemic of influenza last year had affected every thirteenth member of the insured population, and had caused one-fourteenth of the whole amount of sickness during the year, costing in Scotland alone nearly £200,000. At the same time the nation was fitter than it was twenty or thirty years ago, and the population was not really C3, although there were so many days of illness. Only 25 per cent. of the insured population had some sickness during the year; 75 per cent. were fit throughout the twelve months. Half the total volume of incapacity was due to long-term illness not confined to people in the older age groups. The chief factor responsible for long-term illness in young people was tuberculosis.

At the concluding session of the conference a proposal that dental and ophthalmic benefit should be provided under the National Health Insurance Act for all insured persons was discussed. It was mentioned that the Merthyr District Miners' Society had provided dental benefit for all members during the past five years at an average cost of 4s. 5d. per member. Taking this as an index, the total cost of dental benefit for 18,000,000 insured persons would be £3,975,000. It was pointed out by several members that the whole question was one of finance, and that it would be necessary either to agree to a system of pooling services or to increase the contributions. It was stated that Sir Kingsley Wood had calculated that it would cost £7,000,000 to provide statutory dental treatment, and on the basis of members paying half costs £2,000,000 a year was being spent at present on such treatment. An extra 3d. a week of contribution would be required to meet this additional service. The proposal was defeated.

Atrophic Rhinitis

SIR,—I am indebted to Dr. James Adam (*Journal*, June 4, p. 1236) for calling my attention to the fact that in my article on the treatment of atrophic rhinitis (May 28, p. 1167) I did not make it sufficiently clear that patients with atrophic rhinitis are only susceptible to pulmonary tuberculosis. I did not mean to imply that tuberculosis was an aetiological factor. I cannot agree with Dr. Adam when he says that atrophic rhinitis is the result of undiagnosed sinusitis, and that the treatment of the sinusitis cures atrophic rhinitis. I have searched a large number of these cases for proof of sinusitis by antral puncture and by *x*-ray examination, and have not found any indication of sinusitis. In my opinion, and that of a large number of my colleagues, there is no aetiological connexion between the two conditions. The problem of atrophic rhinitis is much more difficult than the treatment of sinusitis. It is significant that true atrophic rhinitis has been much less common in recent years since the great improvement in the feeding and housing of the hospital class of patient. It is true that a pseudo-atrophic rhinitis does occur occasionally after severe operations for chronic sinusitis. I hope that Dr. Adam's letter will stimulate the continuance of the investigation of the aetiology of atrophic rhinitis and its relation, if any, to sinusitis.—I am, etc.,

London, June 13. EDWARD D. D. DAVIS.

Funeral Directors (Registration) Bill

SIR,—In your brief reference to the moving of the second reading of this Bill (*Journal*, June 11, p. 1287) you state that the motion was withdrawn. The motion was not withdrawn, but negatived, as the *Hansard* report correctly states. I shall be grateful if you can insert this letter in your next issue.—I am, etc.,

London, W.1, June 14. HORDER.

Universities and Colleges

UNIVERSITY OF CAMBRIDGE

At a congregation held on June 9 the following medical degrees were conferred:

M.D.—T. F. Fox, J. S. S. Fairley, G. Simon.
M.CHIR.—P. H. R. Ghey.
M.B., B.CHIR.—*C. G. Jobbins, R. D. Teare.
M.B.—*P. G. Levick, A. Innes, S. H. Barnett.

* By proxy.

UNIVERSITY OF LONDON

The entry fee for the M.B., B.S. examination under the revised regulations is £15 15s.—that is, £5 5s. for each of the three parts. Part I will be held for the first time in November, 1938, and Parts II and III in May, 1939.

The first two paragraphs of the regulations for the M.S. examination, Branch I (*Red Book*, 1937–8, pp. 289–90; *Blue Book*, September, 1937, p. 833) were amended to read as follows:

"A candidate for the degree of Master of Surgery, Branch I, must have taken the degrees of Bachelor of Medicine and Bachelor of Surgery in this University. The candidate must forward together with his entry form (1) a certificate of having held for at least two years an approved surgical appointment or appointments at a hospital with an associated medical school recognized for this purpose. In special cases the University is prepared to approve one year's whole-time appointment in a special surgical clinic at a non-teaching hospital as one of the two years' experience referred to above, and (2) a record of operations performed by him, signed by the surgeon or surgeons under whom he has worked."

The Senate on May 18 awarded the degree of Ph.D. in Biochemistry to A. E. Kellie (Lister Institute of Preventive Medicine).

The following appointments were made: Mr. Philip Turner to represent the University on the Educational Board of the British Social Hygiene Council; Dr. R. A. Young to represent the University at the twenty-fourth Annual Conference of the National Association for the Prevention of Tuberculosis, to be held in London from June 30 to July 2. It was reported that, as a matter of urgency, the Vice-Chancellor had nominated Dr. A. M. H. Gray and Mr. W. Girling Ball for appointment to represent the University on the Council of the London (Royal Free Hospital) School of Medicine for Women. Sir Cooper Perry has been appointed representative of the University on the governing body of the Battersea Polytechnic Training School for 1938–9.

Lieutenant-Colonel H. E. Shortt has been appointed to the University Readership in Medical Parasitology tenable at the London School of Hygiene and Tropical Medicine, and is assigned to the Faculties of Medicine and Science.

The following candidates have been approved at the examination indicated:

THIRD M.B., B.S.—*‡W. H. J. Baker, *†K. P. Ball, *†J. P. Bentley, *§A. J. Bernfeld, *†‡¶I. M. Hall (University Medal), *†L. A. Ives, *§T. Parkinson, *§W. M. L. Turner, Sheila M. Anderson, Evelyn G. Ashton, C. E. Aston, A. H. Bacon, Janet E. Bottomley, C. M. Bowker, Katharine M. H. Branson, F. J. Brice, K. P. Brown, J. C. McC. Browne, Marjorie G. Bryan, J. A. Chamberlin, L. J. Clapham, E. M. B. Clements, J. W. C. Cochrane, A. Cohen, A. L. Collins, H. Cooper, Frances M. Cox, R. V. Coxon, W. V. Cruden, Eleanor Davies-Jones, E. C. Dax, J. de Swiet, Nancy K. Dick, J. H. Dobree, E. G. Dolton, Cecile R. Doniger, J. J. Dubash, Gertrude L. E. Dudderidge, Avis M. Dyer, D. F. Eastcott, G. F. Edwards, T. K. Elliott, Winifred M. Emmet, P. G. Epps, G. A. Fairlie-Clarke, D. W. Fell, W. B. Foster, Audrey U. Fraser, E. D. B. Freedman, A. S. Garrett, Edith Gilchrist, B. F. B. Gulliver, H. E. Hobbs, M. A. Imray, J. G. H. Ince, Stella M. Instone, H. Jackson, S. Jackson, Ursula James, E. Japha, T. H. Jenkins, R. C. Jenkinson, P. H. Jobson, E. C. Jones, G. B. Jones, J. M. Jones, J. H. H. Keall, H. A. Kelsey, J. W. L. Kemp, B. W. Lacey, L. P. Lassman, J. D. Laycock, J. A. Lewis, B. G. A. Lilwall, E. L. Loewenthal, W. H. McDonald, Norma M. MacLeod, Constance A. Mallett, A. D. Messent, Agnes M. D. Milne, D. N. B. Morgan, D. W. Moynagh, G. M. Müller, F. L. E. Musgrove, W. M. Owen, Eileen B. Palmer, W. M. Philip, Frances J. Pounds, K. W. Powell, K. J. Powell, R. E. A. Price, Dorothy M. Pritchard, S. H. Raza, E. G. Reynolds, R. Rhydwen, Gwen Richards, H. J. Richards, Mary C. Rowe, S. T. Rutherford, J. M. Smiles, D. J. N. Smith, K. Smith, F. E. Stock, Alizon F. Stookes, B. D. Stutter, N. G. G. Talbot, K. H. Taylor, I. E. J. Thomas, P. Tomlinson, Eileen W. Town, G. C. Tresidder, Ivy M. Tuck, D. M. Wallace, H. P. Watts, J. C. Watts, Aileen E. M. Whetnall, D. I. Williams, T. G. Williams, A. D. Willis, A. R. Wood. *Group I:* B. S. S. Acharya, J. D. F. Armstrong, E. A. Atkinson, R. G. Bartelot, C. A. Bathfield, K. M. Bhansali, W. E. W. Bridger, A. A. G. Clarke, J. C. A. L. Colenbrander, J. H. L. Conway-Hughes, A. H. Cutting, A. P. Dale-Russell, A. S. Dods, A. M. Edwards, J. A. P. Evans, R. W. Evans, C. G. Fagg, W. Fine, H. Foster, Ysobel M. Garland, S. Garnjana-Goonchorn, G. N. L. Godber, L. J. Grant, L. A. T. Hamilton, S. R. T. Headley, R. N. Herson, C. W. Horncastle, N. C. Horne, S. T. H. Jenkins, C. C. Kirby, R. P. Lawson, C. V. Lewis, E. M. Lloyd-Davies, S. Locket, V. D. Logue, M. C. W. Long, Elizabeth C. Marshall, I. J. Mathias, P. S. Meyrick, G. S. Moore, J. N. M. Parry, K. G. Pascall, Nancy Perry, Gloria H. Platt, A. B. Pollard, Nancy E. Robbins, Margaret D. Snelling, C. J. Stewart, R. L. Thompson, D. C. Tomlins, P. E. R. B. Unwin, F. H. Vieyra, Betty Walker, M. H. G. White, R. A. White, R. J. Whiting, Nona E. Wright. *Group II:* W. E. Clarke, Dorothy L. Crossley, D. G. Evans, E. O. Evans, C. C. Evill, D. S. Foster, M. Halberstaedter, Violet E. N. Harris, Mary C. Hopper, Doreen Jamieson, P. H. Jayes, Ruth Jones, G. Kruatrachue, R. J. H. McMahon, S. W. Maxwell, M. T. Read, H. M. Rice, K. S. Richard, R. B. K. Rickford, D. K. Sambrook, J. R. Simpson, D. A. Skan, G. R. Staley, K. B. Thornton, J. W. Warrick, W. R. W. West-Watson, R. F. Wyatt.

* With honours. † Distinguished in Medicine. ‡ Distinguished in Pathology. § Distinguished in Forensic Medicine and Hygiene. ¶ Distinguished in Surgery.

UNIVERSITY OF SHEFFIELD

At its meeting on June 10 the Council appointed Professor G. A. Clark, M.D., the representative of the University on the General Medical Council.

The Council accepted, with regret, the resignation of Dr. Duncan Cameron of the post of honorary demonstrator in anatomy and accorded him its thanks for his services to the University.