ment which, to quote our Royal President "sets out clearly and concisely just what general practice is all about"[4].

There is, of course, no harm in all this, *provided the statements of Council reflect accurately the consensus of opinion of the college membership.* But do they? Does our Council submit its policy statements to critical scrutiny by the Faculties, and by the membership, before they receive the *imprimatur* of the College? Are we, in fact, sufficiently democratic? I do not think so.

As a College, we are unique in our faculty organisation. It is time now, I submit, to put this unique structure to better use. Much more power should be delegated from the centre to the Faculties; they should play an active part in formulating and monitoring college policy. It will, of course, take longer to reach decisions; this is a penalty paid by all democratic institutions, and it is infinitely preferable to the cabalistic rule of authoritarian regimes.

Secondly, let us consider the world of general practice outside our own tight little college membership. When the present criteria for membership were established, the distribution of that membership within the general-practice community was crystallised. We badly need to map out this distribution throughout the country. We shall find lush areas where a high proportion of the general practitioners are members of the College, and wide expanses of desert where the college representation is virtually nil. I believe that one of the top priorities of our College should be to fertilise these deserts.

For better or for worse, the time may come when a young doctor aspiring to the position of a principal in general practice will have to gain his M.R.C.G.P., in much the same way as a hospital consultant is now required to show some higher qualification as evidence of his training. If and when this happens, within a few decades *all* general practitioners will be members of the College, and the deserts I have spoken of will disappear. Can we afford to wait that long? I think not.

I believe we were mistaken to tighten our criteria when we did, so excluding permanently from membership very many general practitioners of high quality, and leaving the distribution of our membership permanently unbalanced. It is perhaps too much to ask that the policy be wholly reversed. But we are not going to tempt many of these experienced non-collegiate colleagues of ours, now in their forties and fifties, to submit themselves to examination before seeking entry to the College.

I would like to suggest that they be offered some special form of associate membership, granting them a status within the College not too far removed from that of a fully established member. If this idea be rejected, then I believe we should address ourselves to rectifying the maldistribution of our membership in some other way. We cannot afford to continue to ignore this thorny problem.

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PRESCRIBING IN GENERAL PRACTICE

Sir,

Since the paper on the prescribing of barbiturates and their substitution by nitrazepam was written, further developments have taken place.

Six patients of the original 116 are no longer with us, four having died and two having moved away, but none of our patients are now on more than 10 mg of nitrazepam. None of them need added chlorpromazine, and of the 110 patients remaining under review, 54 are on no sedation, the others now being equally divided between a nightly dose of 5 mg and 10 mg. This represents a reduction in hypnotic use of 62 per cent.

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CHAPERONES

Sir,

Members of the Medical Defence Union have been advised that accusations of impropriety are made with such unpredictability, and such frequency, that examinations of females should always be chaperoned.

Many general practitioners, none the less, examine without. In the other scale are the points that many women prefer no third party present, that examinations, troublesome (by reason of disturbing staff), are that much more likely not to be done at all, and that the burden on staff is impossible to accept.

A consecutive series of 530 consultations of unaccompanied post pubertal women was analysed. The policy of the doctor was to examine where medically indicated.

Examinations with a chaperonable element were scored:

1. Genital: vaginal and rectal

2. Breast: including stethoscope examination
3. Other: full abdomen, some orthopaedic tests, some ophthalmoscopy
4. Verbal extended consultation on sexual relations.

Total	530	%
Breast	76	*14*
Genital	67	*13*
Other	87	*16*
Verbal	9	—

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MIGRAINE AND THE SPREADING CORTICAL DEPRESSION OF LEAS

Sir,

Leas in 1944 described a phenomenon of a wave of complete electrical inactivity of the cortex initiated by a strong repetitive stimulus. The wave spread at about 0·5 mm per second in all directions but would not cross the midline. Its advancing edge is a zone of intense electrical activity. In migraine the visual disturbance is often a field loss with fortification spectra around its margin.

The points of similarity between the two phenomena are obvious so that it is reasonable to advance the hypothesis that migraine is the subjective aspect of spreading cortical depression. Since spreading cortical depression can easily be produced in the experimental animal it holds promise of a new method of pharmacological investigation of the treatment of migraine.

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REFERENCE

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CHEWING GUM

Sir,

As a long-time gum chewer and research mathematician, I would like to add a mediating note from across the ocean to the apparent contradiction raised in the letter from Dr T. Paine referring to the study by Dr Godfrey D. Ripley.

First it should be noted that there are a number of ways to analyse a given set of data. The stated results of one in six appears to come from performing a "Z" test on the numerical differences between the number of colds in the base and test years in the two groups. However, since the research was designed to investigate the prophylactic effects of chewing gum and since cold frequencies vary from year to year, a more plausible analysis would be to compare the number of subjects in each group who experienced a decreased number of colds in the test year. Dr Ripley's Table I becomes:

	chewer	*non-chewer*
Decreased number of colds in test year	31	23
Same or increased number of colds	9	17

Using the formula for chi-square corrected for continuity we calculate a value of 2·79 ($p<.05$—1 tail, since the difference is the hypothesised direction).

Thus, we obtain a result which is significant at the cherished five per cent level. However, even if an alternate analysis were not possible, I would question Dr Paine's implicit notion that either you have significance at the five per cent level or you have nothing meaningful. It seems clear that if there is any reasonable chance of a prophylactic effect from something as easy and pleasurable as gum chewing that the benefit to risk ratio is very high. Additional studies would therefore seem to be very worthwhile.

The crucial point is that statistical significance level should be based on the relative costs of the type I and type II errors, not on any arbitrary fixed standard. I hope the preceding will provide the reader with something significant (!) to chew on.

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GENERAL PRACTITIONERS AND CONTRACEPTION

Sir,

I feel that Dr A. J. Dalzell-Ward, Chief Medical Officer of the Health Education Council, (January *Journal*) is not taking sufficient account of the lamentable failure rate of so many contraceptive methods. Ann Cartwright, in her study, *Parents and Family Planning Services*, found that two fifths of the mothers in her sample said they had become pregnant, at least once, at a time when they and their husband were using some method of birth control.

While it is true that by no means all unwanted conceptions result in unwanted babies, it is probably also true that the majority of unwanted babies begin as unwanted conceptions, and that