

indication of worse to follow. This is frequently due to an appliance which is too large, less often to the material of which it is made. I would therefore stress the following safeguards: (a) the patient should receive a full gynaecological examination before a pessary is fitted; (b) the initial fitting of the appliance should be done by an experienced doctor with a full range of sizes at his disposal; (c) it is a good working rule that if the patient can appreciate the presence of the pessary it is too large; (d) the pessary should be changed at regular intervals, generally not exceeding 12 weeks, and at each change the vaginal mucosa should be carefully inspected. The patient should also be warned to report earlier if discomfort, discharge, or blood-staining should occur. (e) If vaginitis is found on inspection the pessary should be left out, and admission for operation expedited.

With these safeguards such cases as those reported by Professor Russell should never occur, although, I appreciate, there are some patients for whom no one can budget.—I am, etc.,

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STANLEY W. WRIGHT.

The Contraceptive Pill

SIR,—I have read with interest the letters by Dr. A. I. Klopfer (November 18, p. 1354) and Drs. Eleanor Mears and G. I. M. Swyer (December 2, p. 1494); besides the fact that I fully agree with Dr. Klopfer, according to whom the antioviulatory action of the "contraceptive pills" is due only to the oestrogen added to the progestin or formed in the body as a metabolite of the progestin itself, I would like to discuss briefly Drs. Mears's and Swyer's statement about the supposed antioviulatory action of 17 α -acetoxyprogesterone cyclopentyl-enol-ether ("gestovis"), prepared and studied in our laboratories.

Researches carried out in rats by Falconi *et al.*¹ demonstrated that gestovis, given by mouth, does not interfere with oestrus, mating, ovulation, pregnancy, and delivery at term, even at the daily dose as high as 8 μ moles per animal (whereas not only much smaller doses of 6 α -methyl-17 α -acetoxyprogesterone, but also equimolar doses of progesterone subcutaneously given, have a clear antioviulatory effect). As to the results in human beings, quite recently (December 11) the first symposium on steroidal enol and phenol ethers was held in Rome (the *Proceedings* of the Symposium are already published²); there, many Italian and French gynaecologists confirmed that, according to their clinical experience, gestovis does not have any antioviulatory activity. Dr. Swyer, too, delivered a paper at that meeting, and I think that in his letter he refers to the results he reported in Rome.³ In this instance his statement that gestovis has antioviulatory properties is based only upon the fact that *one* patient, treated from the fifth day of the cycle for 20 days, did not show the increase of urinary pregnanediol usually expected on days 20–22 of the cycle. Now it seems to me that such a statement is a little bit hasty, and does not deserve to be taken into great consideration until substantiated by researches performed in more than one case.—am, etc.,

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RINALDO PELLEGRINI.

REFERENCES

- ¹ Falconi, G., Gardi, R., Bruni, G., and Ercoli, A., *Endocrinology*, 1961, **69**, 638.
- ² *Folia Endocr.*, 1961, **14**, Suppl. 6.
- ³ Swyer, G. I. M., and Little, V., *ibid.*, 1961, **14**, Suppl. 6, 312.

Shortage of Doctors

SIR,—I have read with much interest articles and letters recently published in the *British Medical Journal* and the national press concerning the present and future staffing of the Health Service. The increasing deficiency in the number of doctors in practice is stressed, but no mention is ever made of the pool of doctors who, though anxious to work, are prevented from doing so by the nineteenth-century prejudice against allowing the housewife with a university degree access to part-time professional practice. In particular the urgent problem of junior and middle-grade medical staffing of hospitals could be appreciably diminished were this otherwise.

Since marrying 18 months after graduating from a London hospital I have, despite every effort, quite failed to continue my medical career on a part-time basis. The local hospital management committee, public health department, and blood transfusion service have been alike civil but unhelpful. The only Health Service employment obtained has been full-time general practice in the summer months. Out of 25 women graduates at my own hospital 20 are now married. Of these only three or four work regularly: the others, like myself, are compulsorily idle.

Sir Charles Snow recently stressed the failure of the West to utilize to the full its educated human reserves.¹ "It is one of our major follies . . . that we don't in reality regard women as suitable for a scientific career. We thus neatly divide our pool of potential talent by two." Is it any wonder that we do not view the staffing problems of the Health Service with any great sympathy?—I am, etc.,

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Aylesbury, Bucks.

CHRISTINE THOMPSON.

REFERENCE

- ¹ Snow, C. P., *The Two Cultures and the Scientific Revolution*, 1959. Cambridge University Press, New York.

SIR,—In his letter (December 23, p. 1705) Dr. John Fry questions the fact that there will be a "real shortage" of doctors in this country and attempts to support his contention that the present medical manpower is not being used to the best advantage. In doing so he concludes from the following figures, which he produced (see Table), that it appears that Sweden is a very much healthier country with far fewer doctors:

	Doctors per 100,000 Population	Annual per Caput Doctor- visits	Hospital Beds per 1,000 Population	Average Stay in General Hospitals (Days)	Annual General Hospital Admissions per 1,000 Population	Infant Mortal- ity Rates (1958)
Sweden . .	80	2.5	15	14	128	16
Great Britain	110	4.0	Over 10	16	85	23
U.S.A. . .	140	5+	Under 10	7	130	26

It will be noted from this Table that, whilst the average stay in hospital is similar in both countries, the number of hospital beds and annual hospital admissions per 1,000 population are both 50% higher in Sweden than in Great Britain. This increased hospitalization could be taken to mean either that Sweden is a less healthy nation than Great Britain or that the Swedish general practitioners, possibly due to the fact that there are fewer of them *pro rata* than in this country, are unable to cope with the domiciliary care that we undertake. The latter could also explain the annual "per caput" doctor-visits which seem lower than desirable in this country.