results of these discussions will be published in due course.

The implication that pharmacists are overpaid and underworked is an insult. Large numbers of pharmacies are closing every year because of poor or non-existent profit and many more are barely managing to survive. The closure of pharmacies not only deprives the community of a valuable amenity but also increases the pressure on the local surgeries for the treatment of many ailments that could be successfully treated by pharmacist-guided self-medication.

I am sure that many medical practitioners will support me in saying that the local retail pharmacy under the charge of a highly qualified professional man or woman serves a valuable function in the health care team and that the comments of Dr Graham-Evans are both unfair and totally unnecessary.

D WATSON

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W Sussex

SIR,—Dr J N Graham-Evans (4 September, p 585), in suggesting that the way to reduce NHS drugs bill is to make patients pay a proportion of the costs, has glimmerings of the right idea although regrettably his proposed method is completely impracticable. As he implies, the demand comes from patients, and many general practitioners are unable to control this demand for, if they could, why the need for extra financial constraints on the patient? His proposals would also imply a limitation of GPs' freedom to prescribe, since if the patient could not afford the drug of first choice his prescription would have to be a cheaper and possibly inferior medicine.

Accepting these premises, which flow naturally from his proposals, we might consider whether there are other ways of limiting patients' demands without the erection of fianancial barriers, and of course there are. There seems no reason why the system of prescription charges should not be modified so that in place of exempt and chargeable patients we have exempt and chargeable quantities of drugs. Quantities up to the exempt amount would be free to all patients, but above the exempt amount a fixed charge of, say, £1 would be payable by all patients. The exempt quantities could be listed in publications such as the *British National Formulary* or *MIMS*, and since new prescriptions are commonly written after reference to these volumes determination of the exempt quantities should present no new problems for the prescriber while the pharmacist would quickly learn the exempt quantities for commonly used drugs.

Further benefits might be expected from such a scheme. If the exempt quantities were rational—say, 90 tablets for a drug normally given three times a day—a closer correlation might be expected between the length of treatment prescribed and the period between consultations, with the result that patients would be much less likely to accumulate excess quantities of medicines and very much less likely to give or sell supplies to other people. In short, quantity rationing would engender anew in patients the respect for medicines that over-liberal prescribing has almost destroyed. Pharmacists might also be able to reduce their stockholding, and this could be especially important for it can be shown that it is the impossibility of financing present-day stocks of drugs from present-day NHS dispensing gross profit which is responsible for the alarming rate of closure of chemist's shops.

Naturally there will be exceptions, patients for whom large quantities of drugs are essential, and for these cases there could be a declaration on the back of the prescription to be signed by the prescriber that in his clinical opinion the quantities of drugs specified were essential for the patient. The prescription would then be free, but naturally the DHSS would be entitled, when formally investigating a doctor's prescribing, to expect to be told the basis for the clinical opinion that the patient needed large quantities.

Under this proposed scheme limitation of clinical freedom is minimal except for the irresponsible, and if consumption of drugs is excessive—that is, if it is above actual requirements for the patients under treatment—then there should be no increase in work load for either doctors or pharmacists.

R GARTSIDE

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Career preferences

SIR,—The survey of doctors graduating in 1974 reported by Professor J Parkhouse and Mr C McLaughlin (11 September, p 630) raises several issues, three of which deserve special comment.

It would be understandable if the apparently strong vote of confidence in general practice by young doctors were to leave some hospital colleagues feeling threatened. However, the fact that in the past over 40% of doctors entered general practice anyway suggests that what is happening is that a greater proportion are entering by intent rather than by default —which we should all welcome because it is likely to lead to better patient care.

Secondly, there are implications for postgraduate vocational training for general practice. The figures should help some consultants in hospital disciplines relevant to general practice to face the reality that, contrary to their belief, many young men (and women) do *not* intend to go on to take postgraduate diplomas to fit themselves for specialist training in hospital. Such consultants might come to see that their much-needed help could be given more profitably to active participation in schemes of training for general practice.

Thirdly, there may be disturbing implications for undergraduate education. The apparent failure of the important disciplines of geriatrics and community medicine to attract the young to their ranks may indicate more than the recruiting problems on the service front. Could the figures also be an indication of negative attitudes to care of the elderly and to health services research? I hope that all concerned with undergraduate medical education will seriously consider this possibility and take appropriate action.

JAMES D E KNOX

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Screening for cervical cancer

SIR,—Your leading article on this subject (18 September, p 659) raises a number of important points relating to the efficiency and efficacy of screening programmes.

There is no doubt in my mind that systems which depend largely on action taken by the women alone will fail consistently to include the majority of high-risk women in social classes IV and V. For this reason my own screening programme[1] was incorporated in the normal routine of primary medical care. In this way 700 out of a possible 774 women between the ages of 20 and 60 in the practice were screened and seven positive smears were detected.

False-negatives are always a problem, and an efficient technique of taking the smears is as important as their interpretation.

Taking smears during pregnancy is a possible system, but this has the disadvantage that pregnancy itself may produce cells which look suspicious.

My series also includes the detection of one case of endometrial carcinoma, thus emphasising the comment in your article.

Attention was drawn to the GP's role in this field in a leading article in 1964.[2] I think the DHSS "public policy" is still outdated and revision is essential if screening programmes in general practice in this country are to play a major role.

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[1] Lawrence, R A A R, *Journal of the Royal College of General Practitioners*, 1968, **16**, 379.
[2] *British Medical Journal*, 1964, **2**, 1410.

Malaria threat to the Seychelles

SIR,—In July this year the Seychelles became an independent state. One of the main tasks of the new government is to improve the economy of the country, consisting of 90 islands inhabited by some 60 000 people, and to derive higher financial benefits from the present popularity of the Seychelles as an important centre of tourism. Problems of imported disease, following the greater speed and volume of air communications, are well known to the readers of this journal. But it may surprise some of them to learn that a "tropical paradise" like the Seychelles may now face the danger of malaria, brought to the islands either from Africa or from Asia.

There has never been any evidence of indigenous malaria in the Seychelles for the simple reason that anopheles mosquitoes are absent from the main islands.[1] However, the probability of *Anopheles gambiae*, the most dangerous malaria vector in Africa, establishing itself in the Seychelles must not be ignored. This particular mosquito invaded north-eastern Brazil in the 1930s when the southern transatlantic air route was opened by the French; it took eight years to eradicate it from the New World. Other examples, including that of Mauritius, are well known.

Regular and ever-increasing flights now connect Mahé, the main island of the Seychelles, with Nairobi, Addis Ababa, Djibouti, Dar es Salaam, Bombay, Colombo, and Mauritius, all malarious areas (with the exception of the last, where the disease has been eradicated[2] though the vector is still present). The medical authorities of the Seychelles are not unaware of the health problems arising from the steady increase of communications by air and sea and have deployed at the Mahé airport a reasonably efficient system of disinsectisation of incoming aircraft. However, a much greater degree of vigilance is needed now and in the immediate future, when larger planes with the passenger