Children and Young Persons Act 1969 ("his proper development is being avoidably prevented or neglected or his health is being avoidably impaired or neglected or he is being ill treated") and section 1 (2) (f) ("he is in need of care or control which he is unlikely to receive unless the court makes an order") have to be proved. While it is relatively easy with medical evidence to prove the first part of this, it is not always the situation with the second part.

Finally, it must be remembered that courts do vary considerably, and the same case taken before different courts could be dealt with in very different ways, with sometimes a detrimental effect on the child and its family.

COLIN WEAVER
Senior Officer—Non-Accidental Injury, Kent County Council

Maidstone, Kent

Oral contraceptives and hypertension

SIR,—The association between the combined oestrogen-progestogen oral contraceptive pill and hypertension is now widely known. However, it seems that the incidence is higher than the 5% found in the study by the Royal College of General Practitioners.[1]

I recorded the findings in 100 consecutive women coming for repeat prescriptions of the combined pill and found that 28 of them had a raised blood pressure (systolic ≥ 140 mm Hg, diastolic ≥ 90 mm Hg, or both). Three of these already had a similar blood pressure reading before starting the pill and are continuing on the pill. The remaining 25 were taken off the combined pill; 19 of them were changed to Micronor (containing 0·35 mg norethisterone only) and six decided to use other methods of contraception. Of the 19 patients on Micronor, eight showed an appreciable fall in blood pressure after three months, five showed a slight fall, and six showed no change. Of the six using other methods, four showed an appreciable fall and two a slight fall in blood pressure.

ANDREW MILLAR

Benson,
Oxford

[1] Royal College of General Practitioners, *Oral Contraceptives and Health*. London, Pitman Medical, 1974.

Detection of scanty blood parasites

SIR,—Air travel has resulted in blood parasites from tropical regions appearing in geographical areas where they are not usually found. This situation may give rise to diagnostic difficulties which are often compounded by the scarcity of the parasite in the blood film. Use of the standard blood smear with Romanowsky staining will confirm the clinical diagnosis in many instances, but we have found this approach, even when combined with thick preparations, to be considerably less efficient than examination of the buffy coat for both trypanosomes and malaria parasites. Two recent examples illustrate the point and emphasise an additional benefit from the latter approach—namely, the ability to recognise morphology since red cells are intact.

One week after returning from the tropics a young man developed fever and rigors. A blood film showed the presence of numerous trophozoites of *Plasmodium falciparum*. He was treated with conventional antimalarial therapy and made an uneventful recovery. He subsequently developed a low-grade fever. At that time physical examination was unremarkable and repeated studies of thick and thin blood films failed to demonstrate any parasites. Examination of the buffy coat, however, showed the presence of very scanty ring forms and an occasional gametocyte. Further therapy resulted in complete remission of his symptoms.

The second patient was suspected of having malaria and a blood film showed scanty trophozoites of *Plasmodium ovale* after a long search. However, these were immediately and easily demonstrable on buffy-coat examination despite there being far fewer erythrocytes present. The explanation of this phenomenon is not clear, but it is presumably related to differences in density between normal red cells and those containing malaria parasites.

These two cases illustrate the ease with which scanty blood parasites may be demonstrated by using a simple and readily available laboratory technique. Furthermore, the plasmodia may be characterised more easily than in thick films or in those prepared using the cytocentrifuge,[1] in both of which techniques the red cells are lysed before staining. Since treatment varies to some extent depending on the species of parasite present, accurate identification may have advantage for patient management.

We would be interested to hear whether this experience is shared by other workers.

MAURICE CONRADIE
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[1] Goldsmith, J M, and Rogers, S, *Central African Journal of Medicine*, 1975, **21**, 160. July 1975.

Venereal disease nursing supervisors

SIR,—I would like to emphasise the present serious plight of venereal disease nursing supervisors, most of whom hold the fellowship of the Institute of Technical Venereology and are registered medical auxiliaries.

VD nursing supervisors have from the beginning of the National Health Service traditionally been paid intermediately between the grades of staff nurse and charge nurse. Since the Halsbury Report was implemented the VDNS has now been absorbed for salary purposes into the grade of staff nurse, but still retains the title VDNS. He therefore appears to have been downgraded both in his valued role as a senior member of the venereal and sexually transmitted disease health care team and also penalised financially. In actual fact he receives less than a staff nurse, since a VDNS is still not entitled to the £93 pa VD nursing allowance.

These effects are having a disastrous effect on the morale of existing staff and can only further aggravate the difficulties already existing in recruitment for this essential service.

DAVID R BOURKETTE-BOURKE
Secretary-General,
Institute of Technical Venereology

Tilbury, Essex

Reassurance from British Columbia

SIR,—I wish to inform any doctors contemplating a move to British Columbia that the medical college's rule on immigrant doctors having to spend five years in northern British Columbia (4 October 1975, p 46) has been suspended. This was the result of a decision by the Human Rights Commission which maintained that the rule was discriminatory to foreign doctors.

D L SWEENEY

Vancouver General Hospital,
Vancouver, BC

Restriction of right to prescribe

SIR,—We write again because of the urgency of the matter, in relation to the pernicious Medical Practitioners (Restriction of Right to Prescribe) Bill (12 June, p 1471).

It would be expedient for all medical practitioners to acquire and examine this document which, if enacted, would give "big brother" even more power. There would be for the doctor a denial of freedom with responsibility and an infringement of the patient's right to confidentiality.

There is already too much power in the hands of the State and the lust for more power is insatiable. It would be tragic if our apathy resulted in our being State automatons.

J H SCOTSON
B CAPLAN

Timperley,
Cheshire

Council and the divisions

SIR,—At the last meeting of the Dudley Division grave disquiet was expressed at the present state of health of the BMA divisions.

Democratic, properly organised, thoroughly representative of the profession as a whole and all of its crafts, the division can discuss the problems of the profession thoroughly with all shades of opinion expressed and reflected. Yet the Council and the Representative Body consistently fail to use it. The method of pinpointing issues for discussion by the divisions and thence formally incorporating their opinions into Council policy for action would lead to a thorough knowledge of the problem and the need for action, rather than the present call for action when concurrently attempting to explain the issue under discussion. The need to discuss the problems of professional interest as a whole, craft interests, and the facets of ethical relationships with patients and the administration are too obvious to detail at this point.

Each time a ballot or a referendum is called for by the profession then the BMA undermines its very existence by concurring. The ballot as a mechanism is misleading as to statements of fact, expressions of opinion, and the form of action called for. Each time such a ballot is published, the divisional death knell is rung. Up goes the cry for breathless headcounting, when in fact what we have been waiting for is courageous leadership based on solidly expressed opinion coming up from the divisions. We need more than to recount the old ground of the Annual Report of Council and then have an Annual Representative Meeting as a vote of confidence in their past policies.

It is high time that the Council detailed the programme of discussion and report back, month by month, for the divisions and slowly rebuilt the foundation for the 55% of the profession who consistently pay their dues