CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

As stated each week in "Instructions to authors" no letter will be acknowledged unless a stamped addressed envelope or an international reply coupon is enclosed.

How to organise an international medical meeting

SIR,—As one who attends more than his share of international meetings I have read the early parts of the series of articles by Mr Ian Capperauld and Mr A I S Macpherson with admiration. However, isn't it high time more of us began to ask more insistently, "Why organise an international meeting at all?" I have never been to one which has not been (by widespread consent among the participants) a thorough waste of time and (usually other people's) money.

Short original papers are inappropriate to such a general audience and should be confined to specialist societies which are in a position to judge them or published in refereed journals. The poor expert summoned to give a grand lecture is usually prevailed upon to write his wretched reiterative chapter anyway and would be far better occupied writing a well-considered quinquennial (not five-times-a-year) review elsewhere. The only kind of round table or symposium which has any chance of making progress is the restricted, private workshop of about 20 of the world's leading, still active investigators; and even these can be sterile unless papers *and* criticisms of them (with all appropriate references) are circulated in advance to all 20. In this latter case no one gives his paper, everyone discusses critically and constructively all of the time, and no one gets away with the usual undocumented assertions which are too often eventually built into the folklore and often turn out to have little basis. The eventual book in such a case is more useful to the wider audience, the ultimate in present attitudes, needs almost no editing, and can be published within six months because it is mostly ready before the workshop begins. The manufacturers in the trade exhibition would give their money instead to the expenses of the workshop; and surely neither the scientists nor the medical men are nowadays short of opportunities for cheap tourism, which should in any case be a charge on their own rather than the public purse. A plague on international meetings with their opening ceremonies and the statutory array of local geriatric dignitaries, expensive plastic briefcases, their exploitation by the local travel or congress agent, and the ritual attendance of the masses for the hearing of puny papers and the passage of meaningless slides.

If Messrs Capperauld and Macpherson have not planned a final article to answer my question is it too late to encourage them to do so? Will no foundation invite me to help them to try something adventurous and contributory and completely new? Letters in a plain sealed envelope, please. Given a reasonable opportunity I might even cancel my present plans for Copenhagen, Michigan, Ankara, Göttingen, Venice, Jerusalem, Bangkok, and Kuala Lumpur, for all of which I already have present commitments, having just returned from New Delhi, New Zealand, Berlin, Monte Carlo, Modena, South Africa, Amsterdam, and Vienna, all in the past year.

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Preventing Rh haemolytic disease

SIR,—We read your leading article on this subject (29 July, p 307) with considerable interest. It was an excellent review and while we would agree with the comments therein we felt that figures held for the Glasgow Royal Maternity and Women's Hospitals Group over the past 10 years would be worth quoting, since they indicate quite clearly where gaps exist in the present regimen and how this could be corrected to bring about even further reduction in the incidence of Rh haemolytic disease without recourse to antenatal prophylaxis and all it entails.

As in other centres,[1 2] we have seen a remarkable drop in the incidence of rhesus alloimmunisation in the past 10 years despite the fact that these hospitals have become a centre specialising in this condition. The number of cases fell steadily from 113 in 1968 to 10 (8·8% of the 1968 figure) in 1976, though there was a rise to 21 (18·6%) in 1977. Postnatal anti-D immunoglobulin administration has been largely responsible for this fall and, like other centres in Scotland,[3] our figures show that the failure rate is low. Over the 10-year period a total of 3737 Rh-negative women with Rh-positive babies have received Rh immunoglobulin and only 12 of these (0·32%) have become immunised. Fetal bleeding is quantitated by routine Kleihauer testing and injections given within 24 h except at weekends (mean 27 h). Patients are recalled

six months after delivery for full serological investigation (including prepapainised enzyme technique). An 80% return rate is achieved at this clinic and 10 of the 12 failures were identified at this time, the other two being identified only at the next pregnancy. Seven of the 12 patients have had subsequent pregnancies; one was terminated, another aborted, and the remaining five pregnancies produced three mildly affected infants, of which one required exchange transfusion and another received an intrauterine transfusion. There were no deaths.

These figures contrast with those from the Royal Samaritan Hospital for the period from May 1972 to June 1977 (this series had to be discontinued because of area reorganisation). A similar follow-up system was adopted and all Rh-negative patients receiving 50 μg of Rh immunoglobulin following abortion, termination, or ectopic pregnancy were asked to return six months later for serological testing. In all, 362 women received injections and four failures were identified, two abortions and two terminations, giving a failure rate of 1·1%—three times higher than that of the postnatal series. This figure is probably even higher, for in this group the return rate at six months was only 63·5% and it was not practicable to follow future pregnancies in these women. Of the 362 women in the Royal Samaritan series, 99 had spontaneous abortions, four ectopic pregnancies, and the remaining 259 terminations. For spontaneous abortion the failure rate actually stands at 2%, or six times higher than the postpartum series. Obviously this is the group we should be looking at more closely. Many of the women were bleeding at home for several days before admission to hospital. Even after admission conservative treatment was often prescribed and it was only when the abortion became inevitable that anti-D immunoglobulin was given.

Such a high failure rate can only mean that the immunoglobulin is not being given early enough and it would seem advisable that it should be administered at the first sign of bleeding. This could be repeated either when the patient aborts or in a further 2-3 weeks' time if the pregnancy appears to be continuing. Anti-D levels in a patient's serum would indicate when the next injection should be given and follow-up studies on a larger series of patients would give some indication of the optimum interval between injections.

We wish to acknowledge the secretarial help given by Betty A Buchanan.

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[1] Office of Population Censuses and Surveys, *Mortality Statistics: Childhood, 1975*. London, HMSO, 1978.
[2] Tovey, L A D, *et al*, *British Medical Journal*, 1978, 2, 106.
[3] Cook, I A, Scottish Addendum to the Report of the Anti-D Working Party, April 1978.

SIR,—Professor J S Scott (26 August, p 634) makes light of the "logistic difficulties of making available the necessary anti-D for routine antenatal use" and points out that "in recent years supply has outstripped demand and large reserves probably exist."

I am surprised that in this correspondence no mention has been made of the risks taken by the public-spirited male volunteers who are injected with foreign red blood cells to produce this serum. Though no doubt small, they are potentially very serious—that is, serum hepatitis and production of other antibodies which may create a hazard if the volunteer should require transfusion.

I believe all possible precautions are taken to minimise risks, but surely only the amount required should be produced (certainly no great excess, as has been alleged) and it should be used very carefully indeed, weighing the risks on both sides before extending its use, especially in circumstances in which it may prove later to have been unnecessary.

EVA V TREGILLUS

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Hospital equipment "Which?"

SIR,—May I apologise through your columns to Dr Peter Scott (26 August, p 632) for delay in replying to the question from his supplies department about an obligation on manufacturers to provide circuit diagrams? An answer will be sent soon.

Dr Scott's real concern is, however, for comparative information and guidance about medical equipment, a concern which we know is shared by other doctors. If copies of the DHSS publication called *Health Equipment Information* reached him, as it should, it would go some way to meeting his requirements. Some 15 000 copies of each issue are sent out by the Department and I am concerned that they may not have reached many others like Dr Scott who might find them valuable. We will certainly try to improve the system of distribution and to get the publication more widely known. If you choose, sir, to publish this letter it will serve in a small way to bring its existence to the attention of doctors.

We hope that this series of publications will be of increasing interest to clinicians. For a considerable time past the Department has commissioned evaluation studies of certain special items of equipment, normally those newly introduced to the market-place, and more recently introduced an arrangement on a continuing basis at four NHS centres for the comparative evaluation of defibrillators, diathermy apparatus, ECG monitors, and ECG recorders. The results are being written up now and will be published in *Health Equipment Information* by the turn of the year. Dr Scott will be interested to know that as a next step we are starting work on a similar study of anaesthetic equipment.

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Hospital inquiries

SIR,—The form and practice of hospital inquiries at local level, which have become especially frequent in psychiatric hospitals, need scrutiny and clarification to safeguard medical practitioners and other staff and to respect the normal rights in law of the citizen.

For example, a district management team may appoint a small subcommittee to hold what is represented to hospital staff as an "informal" inquiry. This is grossly misleading when what is said at the inquiry is recorded and official action may be taken as a result of it. The procedure is often for the team of inquiry to interview separately staff in the hospital and sometimes to extend an open invitation for statements from anyone who wishes to contribute. Such replies tend to contain adverse comments.

This method is open to wide abuse. Staff are interrogated behind each other's backs. Members of staff being interviewed may be pressured under questioning to concede to critical views that they would prefer not to offer. What has been said in hospital gossip and small talk may be divulged to a third party and cause embarrassment and anxiety. Anything reported which is to the apparent discredit of a person is likely to be pursued by the inquiry team, and the subject of this will find himself expected to prove his innocence rather than having his guilt proved. Anybody with a grudge, an axe to grind, or a paranoid streak of personality has an unrestrained opportunity to blacken a colleague and to make mischief. Issues may be magnified, distorted, and examined in a one-sided way.

The reorganised National Health Service with its more remote administration, its lack of open management, and its more impersonal systems of communication must take more pains to avoid arrangements for inquiry which can be construed as kangaroo courts.

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Antibiotic sensitivity of Staphylococcus aureus

SIR,—Dr Zehra A Hassan and others (19 August, p 536) report that 81·5% of *Staphylococcus aureus* strains isolated from patients attending St Bartholomew's Hospital casualty department were resistant to benzylpenicillin and 7·5% to tetracycline as well. This tallies almost exactly with our computer record of tests done over the last 18 months on strains isolated from infections in sites other than the superficial layers of the skin in 1064 hospital inpatients. Our results were: resistant to benzylpenicillin 82·2%, plus tetracycline alone 7·33% (of 1023 strains), plus erythromycin alone 2·96% (of 1013 strains), plus fucidin alone 0·94%, and to a combination of these agents and benzylpenicillin 2·57% (of 1013 strains). Thus it appears that only the latter strains can now be called "hospital staphylococci." These strains are, in our hospital, common in superficial skin sites including leg ulcers (11·5% of 529 strains tested).

The St Bartholomew's workers note that strains resistant to benzylpenicillin alone make less β-lactamase than multiply resistant strains and, quoting their previous findings,[1] suggest that phenoxymethylpenicillin can be used to treat superficial (if not all) infections with such strains. However, Price *et al*[1] in the paper quoted compared the results of therapy with phenoxymethylpenicillin or lincomycin but omitted a control group given no antibiotics. They stated "it may be that antibiotic therapy does not materially affect the natural course of superficial staphylococcal infection."

Richmond *et al*[2] first discovered that strains of phage groups I and III isolated from hospital sources and resistant to benzylpenicillin alone made less β-lactamase than multiply resistant strains. Rolinson *et al*[3] reported that the minimum inhibitory concentration of benzylpenicillin for a benzyl-