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.

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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-