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MEDICAL PRACTICE

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Telephone confidentiality

SIR,—Breaches of medical confidentiality come in many forms. Users of cordless telephones may not be aware of the risks that they are taking.

When I recently bought a British Telecom cordless telephone from an official sales office I was assured that the device was confidential. It contains, I was told, a gadget that ensures that no one can overhear a conversation. The same device prevents other people from making telephone calls through my set and charging their calls to my account.

I subsequently used it freely to converse with my patients while on call, confident that high technology rendered our conversation safe from prying ears. I was therefore surprised when tuning my radio on VHF to hear my wife's conversation broadcast loud and clear. I confronted British Telecom, whose initial disbelief was modified to: "But you were warned." It turned out that I had overlooked a sentence in the telephone instruction booklet: "As cordless telephones use radio transmissions between the handset and baseset unit, there is potential for accidental or deliberate overhearing of calls."

I subsequently spoke to various retailers who sell cordless telephones and on each occasion was assured that they were confidential and that conversations could not be overheard. They were very surprised when I informed them that this was not the case.

The use of cordless telephones by doctors is widespread and increasing. Most probably do not realise that they are transmitting sensitive, personal information throughout their locality and are blissfuly ignorant of the medicolegal ramifications of this.

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Red cell antibodies

SIR,—It is comforting to see a consultant obstetrician like Mr Alan Palmer (20 June, p 1568) joining blood transfusion specialists in their plea to take seriously red cell alloantibodies, especially in pregnant women.

A proportion of Rh negative women are still becoming immunised despite postnatal Rh immunoprophylaxis. This immunisation is mainly due to antenatal sensitisation (1·5-2·0% of Rh negative primiparas), although some women are not given anti-D after sensitising episodes such as abortions. Antenatal sensitisation may be prevented by antenatal prophylaxis, but, unfortunately, there is insufficient anti-Rh immunoglobulin in Britain to allow the widespread use of such prophylaxis. Supplies of anti-Rh immunoglobulin might be improved if clinicians assisted in recruiting, as plasma donors, women (past childbearing age) and men who have formed anti-Rh.

The incidence of haemolytic disease of the newborn due to anti-c has not decreased. Though the disease is less severe than that due to anti-D, it may cause morbidity and mortality. Since, as Mr Palmer states, most women are immunised against the c antigen (as well as other red cell antigens) by previous transfusions an additional measure (apart from avoiding unnecessary transfusions in premenopausal women) is to type Rh positive women in need of transfusion for the c antigen. Those found to be negative should be given c negative (that is, CDe/CDe) blood, which should not be difficult to obtain "off the shelf" from transfusion centres. Rather than performing "D^u tests" and other unnecessary procedures such as crossmatching blood that is unlikely to be transfused, it would be better if blood banks spent their energy and resources in typing young Rh positive women for the c antigen.

With regard to antenatal serological testing, we agree with Mr Palmer that all women should be tested at booking and, if unsensitised, at about 34 weeks for the presence of atypical red cell alloantibodies in their serum. Furthermore, women must be tested for the ABO and Rh(D) antigen on red cells on both occasions as mistyping an Rh negative woman as Rh positive can have serious consequences. Rh(D) negative unsensitised women should in addition have a red cell antibody screen at 28 weeks. Mr Palmer recommends more frequent testing for women who possess anti-D, anti-c, and anti-K when their partner's cells contain the relevant antigen. We would go further than this. With the appropriate screening cells other clinically significant antibodies (for example, anti-Fy^a, anti-Jk^a, and anti-s) will be detected, and they should be monitored with the same frequency as those Mr Palmer mentions. We would add a word of caution regarding the advice that monitoring of the red cell alloantibody is unnecessary if the consort's red cells lack the antigen. Perhaps conditions are different in Hull, but in our experience there is no guarantee that the "paternal" red cells actually belong to the father of the fetus. The consort may not be the father, and in such cases we exercise a diplomatic silence. We have certainly seen cases of an affected fetus where there should have been no risk of immunisation by "paternal" antigens. We therefore advise monitoring of the