haemorrhage.¹ The sensitivity was 0.1% at most, which is 10 times lower than the sensitivity of our manual technique. We have now developed a flow cytometric test, which has the same sensitivity (0.01% at about 1 in 10000 cells or 0.5 ml fetal blood) as our manual test (AJM de Man, personal communication). With this test it should be possible to screen large numbers of maternal blood samples for small fetomaternal haemorrhage. This could allow the adoption of a policy to reduce the usual dose of postpartum anti-D immunoglobulin below 100 µg because the dose needed can be calculated promptly once the results of the flow cytometric test are available. This policy could alleviate the shortage of anti-D immunoglobulin in Britain and the Netherlands. Use of a low dose of anti-D immunoglobulin post partum might result in enough immunoglobulin remaining for an antenatal programme to be established, as this has been proved to be effective.

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Many cases of sensitisation may be avoidable

EDITOR,—Elizabeth A Letsky and Mahes de Silva advocate the introduction of routine antenatal prophylaxis to prevent Rh immunisation in pregnant women who are Rh negative and careful identification of women requiring postnatal prophylaxis.¹ Though their recommendations may be correct, some of their assertions are unfounded.

In an unreferenced statement the authors state that the main cause of Britain's continuing relatively high rate of sensitisation is failure to identify RhD negative women at risk and to give the standard postnatal dose within 72 hours of delivery. In a recent study of the causes and clinical consequences of RhD haemolytic disease of the newborn in Scotland, failure to give postnatal anti-D immunoglobulin was the identifiable cause of sensitisation in only four of 70 cases between 1985 and 1990.² In contrast, failure of the current guidelines, which had been properly implemented, to protect women from sensitisation was the identifiable cause in 53 cases: 19 cases were definitely attributed to antenatal immunisation in the first pregnancy, and 28 cases could have been due either to antenatal sensitisation in the second or subsequent pregnancy or to failure of prophylaxis properly administered in an earlier pregnancy. These results could be interpreted as indicating that, at least in Scotland, a programme of antenatal prophylaxis would have a major impact on sensitisation of Rh negative women.

However, in a prospective audit of implementation of a programme to prevent Rh incompatibility, which looked at 671 Rh positive babies born in 1120 consecutive pregnancies to Rh negative women, we identified 280 events recorded during

pregnancy that should have resulted in administration of anti-D immunoglobulin, according to current guidelines: the immunoglobulin was given in only 177 of these, usually because the event was not reported to the medical practitioner.³ This observation suggests that many cases of antenatal sensitisation may be ascribed to identifiable immunising events and could in theory at least be prevented by increased reporting of such events by the women themselves. A prospective trial is in progress in the Edinburgh region to establish whether involving pregnant Rh negative women in their antenatal care increases the incidence of reporting of potentially sensitising events.

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Water birth and infection in babies

EDITOR,—I wish to challenge J Rawal and colleagues' suggestion that a baby developed pseudomonas sepsis during a water birth.¹ The organism was not recovered from the blood, cerebrospinal fluid, or urine of the baby, and its presence on the ear and umbilicus is poor evidence that it was the agent of the presumed sepsis. Coliforms and *Pseudomonas aeruginosa* can be found on surface sites of babies without sepsis. Secondly, faecal spillage from the mother into the birthing pool often occurs, and *P aeruginosa* can be found in the gut of healthy people. The mother was the likely source of the organism cultured both from the swabs taken from the baby and from the specimens taken from the birthing tub and its accessories.

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"Tax" on infertility is increased

EDITOR,—Further evidence of the government's penny pinching in the provision of health care was shown recently. The Human Fertilisation and Embryology Authority announced to the fertility clinics that it licenses that the fees levied for cycles of in vitro fertilisation are to be increased from £30 to £40 and those levied for donor insemination are to be increased from £7 to £10.

When this "tax" was first raised in 1991 I stated that it was "unfair, unacceptable, and unprecedented in medicine."¹ During the past three years the government's attitude to the treatment of infertile couples has changed little. Ninety five per cent of couples requiring advanced fertility care still pay for their treatment. Many fertility problems are caused by medical conditions—for example, the sequelae of endometriosis, pelvic infection, and oligospermia—or even have an iatrogenic cause. A government that professes to provide health care to all, equally, "from the cradle to the grave" is manifestly failing to do so. In the case of infertile people, however, not only does the government not provide the treatment but it further penalises them by charging a fee every time they attend for (usually private) treatment. It has increased this fee or tax by a third in the past three years; this is surely against its professed tenet of controlling inflation. The Human Fertilisation and Embryology Authority has no control over the decision to raise this fee: it has been required to collect 60% of its expenditure from licence fees, and this figure will be increased to 70% next year.

Britain is the only country in Europe in which the government does not provide some help with advanced fertility treatment. The government should remove its tax on infertility and address the problem of providing fertility treatment to all deserving couples equally throughout Britain rather than continuing to condone the haphazard system that now exists.

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Managing casualties of war

EDITOR,—We cannot agree with Robin M Coupland's suggestion that military medical forces and their medical planners, working for the United Nations under a humanitarian mandate, should abandon their traditional military approach to managing the casualties of war for an epidemiological one. Two dissimilar situations are being equated to obtain a single doctrine. This will not work.

The driving force for the military is to evacuate casualties from the front line as quickly as possible, administering sufficient care at each stage to allow this to happen; this applies to military and civilian casualties alike. The commander, politicians, the public, and, not least, the patients, however, expect that patients will receive the treatment that they would receive in peacetime in a developed society, although they make allowance for the special circumstances of the battlefield. In addition, patients may be picked up soon after wounding—a situation different from that usually encountered by Red Cross staff.

The military therefore always plan for full medical support based on a comprehensive infrastructure, including support from engineers, good communications, the provision of both pure water and an adequate diet, the availability of medical supplies, and the means of evacuation.

Civilian staff, on the other hand, may find themselves without this infrastructure and have to develop different concepts of triage. Short cuts are taken and ideals for treatment tempered by the situation. Lessons that undermine traditional teaching on the management of war should not be derived from the survival and recovery of the patients of civilian staff unless all pertinent factors have been considered. Like has to be compared with like and differences appreciated.

We suggest there are two important lessons to be learnt in such circumstances. Firstly, medical