or delay the introduction of safe autologous techniques?

Our experience is small, but we are impressed by the simplicity and expediency with which donations can be taken by the clinical team, without imposing a burden on our own haematology department or the transfusion service. A decision to use autotransfusion is usually made at the initial outpatient consultation, and the necessary clinical and haematological assessment has not resulted in any additional delay to admissions. In what way this can possibly be regarded as "an enormously expensive and wasteful exercise with at best marginal effects on patient safety and at worst a significant deterioration" (Dr J A F Napier (7 February, p 441)) defies logic and imagination. In elective surgery there is no place for additional "minimum" risk. Furthermore, there may be advantages in terms of cancer recurrence rates when homologous blood is avoided.¹

We regard autotransfusion as a major step forward, a step which also requires operative blood conservation and measurement of blood loss. A detailed appraisal of ideal tissue perfusion and haemoglobin and packed cell volume as alluded to by Dr J M Cundy (31 January, p 308) seems overdue. While the logistics of autotransfusion may compound difficulties when availability of beds is a problem, as Mr M E Foster and Dr M J Lewis pointed out (31 January, p 307), the 35 day life span of blood does leave considerable room for manoeuvre.

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1 Hamblin TJ. Blood transfusions and cancer: anomalies explained? *Br Med J* 1986;293:517-8.

Annual representative meeting

SIR,—The executive committee of the Southampton and South West Hampshire Division of the BMA, having studied the report of the divisions' representatives at the annual representative meeting in 1986, is concerned that so many motions are now submitted to the meeting that proper debate of many of them is not possible.

We are aware that the purpose of the agenda committee is to arrange priority motions so that similar motions are grouped and debated together, but we believe that this system has become open to abuse. Pressure groups can press for several divisions to put forward motions on a particular subject and thus ensure that the subject will be discussed. A matter of great concern to a particular division, comprising only one motion, has little chance of getting a hearing. The agenda committee is overloaded and so can be manipulated into deciding what will or will not be debated. Furthermore, failure to restrict the total number of motions submitted may well result in individual members or divisions becoming disenchanted with the steadily decreasing likelihood of their motions being debated or considered to be worthy of debate.

We believe that the role of the division is to select those topics of special concern to its members. If the division were limited to, say, three motions the divisional members would have to exercise their own system of priorities in selecting their motions. Thus minority opinion would not be overrepresented as not every division lobbied by others would consider the matter of sufficient importance to constitute one of its own three motions.

In addition, we believe that a similar limitation on the number of motions should apply to the other

bodies submitting motions. If the number of motions submitted were limited in this way we think that the annual representative meeting would have a more manageable agenda covering matters of priority concern to members, which could then be considered and debated more thoroughly.

This division therefore proposes to submit a suitable motion and invites others to support this motion.

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The Savage inquiry: a personal reply

SIR,—After the deafening silence that followed your leading article of 2 August 1986 I am grateful to Mr R J Maxwell for discussing my suspension and the inquiry into my competence. I fear, however, that, in acting from a well intentioned desire to be fair, he has perpetuated what I believe to be one of the many myths surrounding this affair—namely, that "the key problem is one of personalities. . . ."

Anyone who attended the inquiry (or indeed read the final report) could not fail to recognise that fundamentally different approaches to the practice of obstetric medicine were being contrasted and debated. How else can the position be described when Professor Grudzinskas found the five cases to disclose over 50 allegations of incompetence, whereas the distinguished clinicians who gave evidence on my behalf found no substance in any of them?

The real issues, as is often the case, lie a little deeper. To find practitioners with very different approaches working in the same unit is unremarkable, and most of us would accept that a developing and vital profession will encompass a variety of personal styles and attitudes. In my case, however, the prosecution sought to persuade the panel that such tolerance and diversity was wrong and that (in the words of Mr Gordon Bourne) "the only correct approach was that contained in standard textbooks and taught to students."

It may not surprise your readers to learn that Mr Beaumont and his colleagues had little time for this narrow dogma. What I hope will give them cause for real concern, however, is the fact that one of their consultant colleagues could be shut out abruptly from her profession and suspended for 15 months on the basis of a case in which only four out of 54 of the detailed charges were found to have any validity. To dismiss what has happened as a mere clash of personalities is to fail to appreciate how the existing machinery allowed me to be pilloried with arguments and attitudes that command only marginal support within the profession as whole.

If we ignore the history of this affair we will be condemned to repeat it. Unless the fundamental issues are dealt with doctors who are guilty of nothing more than having a different approach from that of some of their colleagues will continue to suffer as I have done, and as two other women doctors in the North East Thames region are continuing to do.

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Ottorino Respighi: bacterial endocarditis in 1936

SIR,—We read with interest the article by Dr David Levy on the death of Gustav Mahler from subacute endocarditis in 1911 (20-27 December 1986, p 1628), a destiny shared by another com-

poser, Ottorino Respighi (1879-1936), 25 years later.

As a child Respighi suffered from rheumatic fever, which left him with a modest cardiac murmur.¹ In the spring of 1935, when he was in Budapest for the Hungarian première of his opera *La Fiamma*, Respighi suffered a severe bout of laryngitis. According to his wife, Elsa, this was probably the start of his endocarditis as the composer never recovered fully and remained disproportionately tired for the rest of the year. In the autumn of the same year he underwent a dental extraction, complicated by a gingival abscess. At the beginning of 1936 he developed a fever and was confined to bed. As the fever persisted a blood culture was performed and showed *Streptococcus viridans*, which was confirmed on several other occasions. Subacute endocarditis was diagnosed.

His doctors were Jakob Wachmann, a friend, and Nicola Pende, a famous clinician in Rome. Because of pressure from friends, who advised him to seek a second opinion, while Pende was out of Rome the patient was visited by another famous clinician from Rome University, Cesare Frugoni, who confirmed the hopeless diagnosis. Respighi's wife kept the severity of the disease a secret from both the patient and his admirers, and only a few relatives and friends were informed of it.

Respighi's final illness lasted about three months. Support treatment included blood transfusions and a preparation of the recently discovered sulphonamides, sent from Berlin, which unfortunately proved ineffective. Respighi died in Rome on 18 April 1936.

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1 Respighi E. *Ottorino Respighi*. Milan: Ricordi, 1954. (Abridged English translation, London: Ricordi, 1962.)

Drug points

Bilateral scopolamine mydriasis in a traveller

DR A SIMPSON (Ciba-Geigy Pharmaceuticals, Horsham, West Sussex RH12 4AB) writes: Transdermal scopolamine is not currently marketed in the United Kingdom. Several reports document unilateral pupillary dilatation after treatment with transdermal scopolamine.¹⁻⁶ A case of bilateral pupillary dilatation has been reported in which a patient placed a transdermal scopolamine disc behind his right ear and immediately afterwards inserted his contact lenses.⁷ Within half an hour both pupils had become fully dilated. It is almost certain that in all these cases contamination of the eye occurred immediately, which may also explain the case reported by Drs Gabriella M Marcon and F Schiavo (24 January, p 250.) A more unlikely explanation would be that the massaging of the patch released an excessively high blood concentration of scopolamine. The information leaflet given to patients states that after the patch is in place the patient should be sure to wash the hands to remove any scopolamine. On removal of the patch patients are again instructed to wash the hands and the area behind the ear. In practice, if any adhesive is on the hands after application or removal of the patch it will contain scopolamine. Subsequent touching of the eye will produce the effects noted. Thus it is not so much transdermal administration that results in these effects but the inappropriate handling of the transdermal system.

1 McCrary JA III, Webb NR. Anisocoria from scopolamine patches (2 cases). *JAMA* 1982;248:353-4.

2 Vincent FM. Cycloplegia from transdermal scopolamine. *South Med J* 1985;78:1527-8.

3 Hodgson T. Preventing motion sickness. *Can Med Assoc J* 1982;126:1374.

4 Chiaramonte JS. Cycloplegia from transdermal scopolamine. *N Engl J Med* 1982;306:174.