rather than the failure of the health authority or the district management team. The superintendent who speaks out on behalf of his hospital runs the risk of incurring the displeasure and pique of authorities.

If the post of superintendent is as incompatible with the new system and as redundant as is widely claimed it would appear reasonable, logical, and fair to give it an appropriate burial on a national basis with guidance from the DHSS on the recompense of those who, through no fault of their own, were appointed to such posts and now find themselves in an uncertain and embarrassing position.

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Amoxycillin, talampicillin, and ampicillin

SIR,—Dr I W B Grant (10 July, p 106) puts forward relevant problems in the prescribing of antibiotics of similar origin and activity, but unfortunately the arguments leading to his concluding statement that "doctors who prescribe the new preparations must be open to the charge of wasting public money" are not wholly accurate.

The *British National Formulary 1976-78* (p 104) does advise the use of amoxycillin instead of ampicillin where high blood levels are important. There is evidence¹ that amoxycillin penetrates bronchial secretions more readily than ampicillin and, unlike the latter, this is not dependent on the level of purulence. Therefore it is preferable in chronic lower respiratory tract infections, while in acute infections the sole advantage is its greater absorption and high blood levels for an equivalent dose.

Comparisons of the costs of antibiotics are open to many interpretations. In the High Wycombe group of hospitals the contract costs of prescribing amoxycillin, talampicillin, and ampicillin in equivalent doses are as follows: amoxycillin 250 mg three times a day, 24 p; talampicillin 250 mg three times a day, 18-6 p; ampicillin 500 mg four times a day, 16 p. The non-contract price in my area for the proprietary compounds, Amfipen and Vidopen, quoted by Dr Grant would be 24 p. The expiry of the patent rights on ampicillin has and will result in a large variety of proprietary brands becoming available, and bioavailability is now a very important factor in the compound chosen by doctors. The peak blood level is not the only important factor in the use of a particular antibiotic compound, but it does provide a basis for comparison. The above dosage of the three compounds results in reported peak concentrations of which that for ampicillin is still the lowest. At the moment amoxycillin is more expensive than the other two penicillins but it has advantages, such as a more rapid bactericidal action against some bacteria and fewer side effects, which make it the most appropriate therapy in certain patients.

My last comment raises the dangers of possibly not reading all quoted references. In our paper² we only made the observation that talampicillin caused fewer cases of diarrhoea in volunteers, had less effect than ampicillin on the faecal flora, and because of the pharmacology it is predictable that its clinical use should be associated with a reduction in the incidence of diarrhoea. The statistical results were reported by Knudson

and Harding,³ who found a significant difference between the incidence of diarrhoea caused by the two compounds, and confirmed by Jaffé *et al.*⁴

The climate of antibiotics has changed. No longer can doctors expect entirely new compounds with enhanced bacterial activity to appear on the market at regular intervals. It is important that more knowledge is acquired about existing compounds, and much research is necessary into pharmacological action and bacterial activity.

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¹ Brogden, R N, Speight, T M, and Avery, G S, *Drugs*, 1975, **9**, 88.

² Leigh, D A, *et al*, *British Medical Journal*, 1976, **1**, 1378.

³ Knudson, E T, and Harding, J W, *British Journal of Clinical Practice*, 1975, **29**, 255.

⁴ Jaffé, G, Murphy, J E, and Robinson, O P W, *Practitioner*, 1976, **216**, 455.

Abortion and maternal deaths

SIR,—In your leading article on this subject (10 July, p 70) you state that "the primary need is for more accurate information about the reasons for the present delay in reaching a decision about whether to terminate a pregnancy." I would like to argue that the primary need is for action on the basis of the information we already possess.

In 1972 this institute carried out a study for the Committee on the working of the Abortion Act which was subsequently published as volume III of their report.¹ This to a large extent answered your question, "To what extent is the patient, the family doctor, or the gynaecologist (indeed the whole system of referral and consultation) responsible [for delays]?"

The study showed that 87% of the random sample of women having an abortion had consulted a doctor before nine weeks had elapsed since their last period and nearly half, 47%, did so before six weeks. On average these women consulted 2.5 different doctors during their pregnancy and before they were admitted to a hospital or clinic for an abortion. The average number of doctor consultations was 3.8. Just over half, 53%, of second and subsequent consultations occurred within one week of the previous one, but for 18% there was a delay of two or more weeks. When a hospital gynaecologist was seen this proportion was 29%, more than four-fifths of these delays being attributable to the doctor or the hospital rather than the woman.

It might be academically interesting to see whether a similar picture still emerges four or five years later, but since there is no reason to believe there has been a dramatic change it would be more appropriate to call for action rather than further research. The setting up of the "well-planned prospective studies" which you recommend could well delay rather than stimulate reform.

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¹ Committee on the Working of the Abortion Act, *Report*, vol III. London, HMSO, 1974.

SIR,—It is quite obvious from your leading article on this subject (10 July, p 70) that while doctors may be good at medicine they are not

always up to date with their statistics. For example, you write that "abortion remains the most common cause of death associated with pregnancy." This was so during 1970-2, but more recent information (from the Chief Medical Officer's Annual Report for England) shows a very significant fall in 1973. In that year the largest single cause of death in pregnancy was toxæmia, with abortion dropping to third place and accounting for only 13.2% of maternal deaths.

Equally misleading is to quote an overall death rate from legal abortion for the years 1970-3 (12.3 per 100 000 according to you), for during that period the death rate fell drastically and in 1973 there were only four deaths attributed to 166 000 legally terminated pregnancies. In fact, the official statistics show 10 deaths each year for 1969, 1970, and 1972, 12 in 1971, and then a maintained reduction to four in 1973 and six in 1974—hardly the "persistent rise in deaths associated with legal termination of pregnancy" as claimed by you.

There is no need to remind you and your readers that abortion is again in the news and that a select committee is soon to report. During the past few years much emotive and inaccurate propaganda has been disseminated in attempts to sway public and parliamentary opinion. I hope you will now publish a further leading article containing up-to-date figures. Then the *BMJ* cannot be accused of adding its voice to those others that have distorted this whole issue and caused much unnecessary anxiety among patients.

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* * * Our leading article was based on the findings of the most recent confidential inquiry into maternal deaths, covering the years 1970-2, and was mainly concerned with avoidable hazards of mid-trimester abortion. True, some later mortality figures are available, but the value of the confidential inquiries is that they draw their conclusions from full information about all maternal deaths. The purpose of the inquiries and our leading article is to bring about a progressive reduction in the mortality and morbidity associated with pregnancy. Even if, as Diane Munday asserts, the death rate from abortion is falling (and we hope it is) we should try to lower it further. —Ed. *BMJ*.

Management of eclampsia

SIR,—In your leading article on this subject (19 June, p 1485) we were pleased to note your support of the recent development of a more rational approach to therapy. In previous years treatment has depended on the production of basal narcosis in the mother, with resultant gross depression of the infant at birth.

In this hospital both eclampsia and severe hypertension in labour are managed with combined anticonvulsant and antihypertensive therapy.¹ Chlormethiazole is a potent anticonvulsant which has proved safe in our hands without producing fetal depression. Apgar scores of 7-10 at five minutes are found in 89.5% of cases. Clonidine hydrochloride given in intermittent intravenous doses produces a satisfactory fall in blood pressure in over 70% of cases.² We have found bolus intravenous injections to be of value in situations where