comment on certain aspects of the study.

The absence of a speech therapist from the assessment team at once raised doubts in our minds. Although the speech therapy profession recognizes the need to re-evaluate techniques and methodology in many ways, assessment procedures are perhaps its forte, if methods of treatment leave much to be desired. The "clinical speech test" on which the assessment of speech was based involved a rating of the child's ability to repeat six sentences covering "most of the common vowels, single consonants, and clusters of consonants used in everyday English speech." It is, of course, very easy to criticize tests used in such situations, but the sentence test devised as a "clinical test" seems to have many shortcomings and cannot be regarded as "potentially valuable as a means of screening." One must conclude that such factors as vocabulary, frequency of usage, and, more important, sentence length and sentence structure were not taken into account in any systematic way. While one cannot deny the diagnostic value of a sentence repetition test in certain specific cases of language disorder, we feel it can hardly be regarded as a satisfactory general screening test for speech. Furthermore, while allowing that non-expert examiners are hardly likely to notice any "defect" other than "mispronunciations" the emphasis on accurate repetition of speech sounds is surely misplaced in the light of recent widely available findings of linguists and speech pathologists, where stress is laid on the importance of investigating language structure, a point taken up favourably by the recent Government report on speech therapy services.¹

One might also wonder how such a procedure would detect children who are echolalic, who may have repeated either the last word in the sentence or indeed the whole sentence in the complete absence of comprehension. How also can a child repeat six sentences of up to seven words without the involvement of auditory discrimination and memory? Recording of a stammer during this test must also be questioned; some child stammerers would perform normally at such a task, but this performance would not necessarily relate to the child's level of fluency at a communicative level.

The factor of high percentage of mispronunciations in the north-west region is of note and it seems possible that dialectal factors might have been significant here. Although the teachers' evaluation of language use and comprehension helps to restore the balance in the right direction, with reference to the low rating of children from manual social class background, we would refer the authors to the studies of Bernstein² and others^{3,4} whose findings demonstrate not so much "language deprivation" but rather the use of language for different purposes, teachers' "language" being that of school and the 7-year-old child still operating with the "home code."

Other more vital points were eventually taken into account, such as visuo-spatial problems and the obvious fact that "poor speech could itself occur as a result of mental subnormality." Yet in the opening summary the authors declare that "the methods used for screening provided a reliable guide in the selection of children who require further investigation."

Those with experience in the field of

speech and language problems will surely agree that the age of seven is too late for screening and it is the younger child whom we should be concerned about. It is to the authors' credit that they recognize this in their conclusion, but it is regrettable that they then seem to recommend school entry age as the ideal time. This is already too late: if a child comes to school with speech and language problems, he will be doubly handicapped since remediation will require his absence from the classroom and his disability will hamper both his educational and social development. Speech and language disorders and delay can be detected and dealt with very early on in the development of language. Let us make the expertise of the speech therapists and others in the assessment and remediation team available to those children with no speech, instead of waiting until the problem is more defined and more severe. Indeed, the whole study serves as an indictment of the services that are available for all children; why are children not receiving advice and help earlier, if indeed they are even being referred for it? Medical practitioners will be asking themselves this question; speech therapists, teachers, psychologists must ask if they are giving the right advice and management. One must hope that this study will motivate all concerned to evaluate carefully the kind of services they themselves are providing.—We are, etc.,

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¹ Department of Education and Science, *Speech Therapy Services*. London, H.M.S.O., 1972.

² Bernstein, B., in *Language and Social Context*, ed. P. P. Giglioli, ch. 8. Harmondsworth, Penguin, 1972.

³ Labov, W., in *Language and Social Context*, ed. P. P. Giglioli, ch. 9. Harmondsworth, Penguin, 1972.

⁴ Honeyford, R., *British Journal of Disorders of Communication*, 1972, 7, 206.

Abuse of Diuretics by Jockeys

SIR,—I have recently been approached by two jockeys racing at Cheltenham for what they call "pee pills"; I did not, of course, prescribe them. On further questioning it appeared that there is a substantial black market in diuretics among jockeys, the most popular brand being Lasix (frusemide). As a rule they take these a few hours before the weigh-in, and the usual dose is from two to three tablets (up to 120 mg) though this may be exceeded. They then have a violent diuresis and achieve a loss of weight of up to about 6 lb (2.7 kg). They then take no further fluids until after the race and the further weighing.

The prospect of the side effects that may result from a high dose of frusemide—hypotension, dehydration, and many others—in someone taking part in a very athletic sport, I find alarming. In this particular sport they are not only endangering their own lives, but the lives of fellow jockeys, horses, and possibly the general public.

Is this situation to be allowed to continue, or should there be some sort of inquiry similar

to that which was applied to athletes and amphetamines?—I am, etc.,

DAVID PRICE

Cheltenham

Erysipelothrix Septicaemia

SIR,—We were most interested in the report by Dr. R. H. Townshend and others (24 February, p. 464), of a case of *Erysipelothrix rhusiopathiae* septicaemia, as we recently had a similar case, though with endocarditis. This patient recovered with penicillin but died a few months later from carcinoma of the bronchus. The presence of carcinomatosis in our patient and of chronic alcoholism in four and hypogammaglobulinaemia in one of the previously reported cases raised the possibility that erysipelo-thrix septicaemia is essentially an opportunistic infection, particularly since it is so rare although the organism widespread in nature and the local skin infection, erysiploid, not uncommon.

We wondered if Dr. Townshend's patient had been receiving steroids for her psoriasis and might therefore have had some degree of immunosuppression. We are not sure that he should so dogmatically state that there was no evidence of endocarditis. The patient had multiple pulmonary infarcts and normal lower limb phlebography; these infarcts might well have been due to septic emboli from a focus of endocarditis and, despite the absence of a heart murmur, this surely must have been the most likely source of emboli, since it is such a characteristic lesion in erysipelo-thrix septicaemia.—We are, etc.,

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Special Risks for Hospital Doctors

SIR,—The recent concern over the lack of proper insurance for doctors at risk in chronic renal dialysis units and in motorway accident teams was discussed at length at a recent meeting of the South-western Regional Committee for Hospital Medical Services. At the request of the committee I would like to express our whole-hearted support for the recent initiative taken by Dr. C. E. Astley, Chairman of the Central Committee for Hospital Medical Services, in making public the concern widely held throughout the hospital service at the intransigence of the Department of Health and Social Security in the matter.¹

We believe that it is grossly unjust, particularly to doctors in the training grades, that their lives should be put at risk in the course of their daily duties without adequate insurance cover being supplied. The cost to the D.H.S.S. would not be great and this would ensure that where death ensued, doctors' families would have adequate pensions.

Under the present arrangements, should death ensue in the course of their work, their future earning capacity is not reflected in the pension their families would get, and recent awards by the courts reflect that future earning capacity should now be considered. We therefore strongly urge Dr. Astley and his committee to continue their efforts on the profession's behalf and wish