that on the figures given "the acute myocardial infarction mortality appeared to be twice as high in the beta-blocked patients as in the control group." The further information supplied by Dr. Oram and his colleagues on the two-year survival of 35 of the trial patients on tolamolol is encouraging but irrelevant to the present argument as they are a preselected group.

I did not discuss my calculations with the authors as I was also interested in the comments from other workers. The fact that I am senior medical adviser to Bayer UK, Pharmaceutical Division, is not relevant to the points at issue.—I am, etc.,

CHRISTOPHER GOOD

Haywards Heath, Sussex

Attitudes towards Alcoholism

SIR,—The unfavourable attitudes found to exist among Scottish doctors and undergraduates towards alcoholism (Drs. E. B. Macdonald and A. R. Patel, 24 May, p. 430; Professor J. H. Barber and others, p. 431) are unfortunately shared by many doctors in England. Your contributors' conclusion that education within the profession is needed holds good for all parts of the British Isles. To a large extent such unfavourable attitudes may be derived from lack of information and inadequate undergraduate training. Like the lay public, doctors often equate alcoholics with psychopathic self-indulgent drinkers who spend their days drunk in the gutter, and they share other equally incorrect prevalent stereotype misconceptions.^{1,2} In our experience, once undergraduates and doctors have come into close contact with or have had personal experience with alcoholics who have recovered from their affliction they often develop quite different positive attitudes towards them. The Medical Council on Alcoholism has in recent years done a great deal to help change the profession's false and unhelpful attitudes. But much more needs to be done, in particular at the undergraduate level. In my experience recovered alcoholics³ can be of great help in this connexion. Certainly occasional lecture-demonstrations held over years with the participation of recovered alcoholic ex-patients at various London teaching hospitals under the auspices of the London Medical Group; regular discussions and demonstrations with undergraduates at University College, St. Bartholomew's, and the Middlesex Hospital have all shown this to be a popular method of arousing interest in this increasing sociomedical problem—in particular when such students later on also attended group therapy sessions with patients at St. Bernard's Hospital alcoholism unit. The same type of lecture-demonstrations have for more than 20 years proved very helpful in discussions with doctors and many other interested professional bodies.^{3,4}

If alcoholics and their families are to be encouraged to present themselves at a much earlier stage, and if the stigma is to be reduced, doctors will have to give a clear lead. They will do so only if they themselves are better educated about the problem in their student days. In addition to the usual methods the willing help given by recovered alcoholics seems to be a very

valuable, but as yet largely untapped, technique.—I am, etc.,

M. M. GLATT

St. Bernard's Hospital,
Southall, Middlesex

- 1 Glatt, M. M., *A Guide to Addiction and its Treatment—Drugs, Society, and Man*. Lancaster, Medical and Technical Publications, 1974.
- 2 Glatt, M. M., *Alcoholism—a Social Disease*, 3rd edn. London, English Universities Press, 1975.
- 3 Glatt, M. M., *British Journal of Addiction*, 1962, 58, 13.
- 4 Glatt, M. M., and Lumb, I., *Pharmaceutical Journal*, 1955, 175, 392.

Late Talkers

SIR,—“My child isn't talking yet, doctor.” There must be very few general practitioners who have not encountered this complaint from a mother and many who, because of the wide range of individual differences, tend to give facile and hurried reassurance. Unfortunately, this is not always appropriate, as there is a substantial minority of late talkers who will need further investigation and help. In view of this many speech therapists, in spite of their long waiting lists, now agree to see children as early as 2 years of age, and this letter is a plea that their recommendations be followed.

Why is this subject important? Several authors¹⁻³ stress that the normal acquisition of speech and language is an essential prerequisite for the learning process and even when endowed with good or average intelligence late talkers are at great risk for the development of severe reading difficulties at school, with consequent educational retardation and behavioural problems. Our society places great emphasis on literacy, and belated attempts at remediation are made at secondary school level or in adult life. Many of these illiterates were undiagnosed, untreated “late talkers” who have not fulfilled their potential.

What criteria should be adopted? If a child in a normal home environment is not using one-word utterances at the age of 18 months the differential diagnosis lies between deafness, mental retardation, autism, brain injury, and a specific language disorder. Screening for syntax (that is, language as distinct from speech) is more complex, but a good working rule is that by the age of 30 months a child should use simple sentences or three-element clause structures. Use of nouns is not sufficient, and one can be misled by a proliferation of naming or by echolalia.

The doctor's frequent reply “Don't worry, he'll talk when he's ready (or when he goes to school)” may be correct in some cases but will have disastrous consequences for others, and I would strongly urge further investigation in any cases of doubt.—I am, etc.,

ELINOR JAFFA

Birmingham

- 1 Tarnopol, L., et al., *Learning Disabilities*. Springfield, Thomas, 1969.
- 2 Francis Williams, J., *Children with Specific Learning Difficulties*. Oxford, Pergamon, 1974.
- 3 Morley, M. E., *Development and Disorders of Speech in Childhood*. Edinburgh, Livingstone, 1967.

Another Unfair Anomaly

SIR,—You do well to draw attention in your leading article (21 June, p. 652) to the plight of full-time university clinicians in

regard to equal pay for equal work. The anomalous situation to which you refer is paralleled by the plight of N.H.S. clinicians undertaking the teaching of medical students. Many of our universities have failed to liaise with hospital authorities to ensure that either contract time or payment is made available for this purpose.

It is certainly time that universities considered how much longer they can continue to be seen as unfair and unjust employers.—I am, etc.,

R. S. MORTON

Special Clinic,
Royal Infirmary,
Sheffield

Identification of High Risk Labours

SIR,—Mr. J. Studd and his colleagues (7 June, p. 545) analyse the results in 741 consecutive spontaneous labours which were conducted in two different hospitals. It is stated that there were no stillbirths, neonatal deaths, or cerebral damage. This simple statement requires elaboration because the most important measure of the success of any method of treatment in labour is the effect on the child. As it is unlikely that the perinatal mortality rate in the Birmingham Maternity Hospital or the Nottingham City Hospital is below 15 per 1000, not less than 10 deaths could be anticipated in 741 consecutive births; cerebral damage is more difficult to identify.

The authors state that patients in labour are examined on admission and managed without reference to the nomogram until the cervix is 2 cm dilated. This implies a retrospective diagnosis. A retrospective diagnosis of labour has the effect of excluding most patients in whom a problem of management is likely to arise, and this is a fundamental mistake. The authors also state that the uterus was stimulated when the duration of labour extended two hours past the nomogram and claim that this resulted in shorter labours, but table I shows that the mean duration of labour in the patients who were stimulated was 12 h 4 min and 11 h 39 min in primigravidae and multigravidae respectively—which compares with 13 h 13 min and 13 h 41 min in patients who were not stimulated. The difference between these figures does not appear to be great enough to substantiate the claim; the figures also appear to suggest that unstimulated labour is longer in multigravidae.

I support the authors' contention that the selection of patients is important but suggest that what the public is rightly questioning is unnecessary induction of labour, not the management of labour that has already started.—I am, etc.,

KIERAN O'DRISCOLL

National Maternity Hospital,
Dublin

SIR,—While agreeing with Mr. J. Studd and his colleagues (7 June, p. 545) about the value of oxytocic stimulation in the treatment of uterine inertia in primigravidae, I should like to question both the need and safety of this treatment in multigravidae.

In my own experience uterine inertia occurring after the spontaneous onset of labour in multigravidae almost always responds, and usually dramatically, to simple low rupture of the membranes. In contrast to the situation with primigravidae this is in fact the