been fulfilled for neonatal neurological screening procedures. Some brain abnormalities which will lead to chronic neurological disorder certainly produce detectable clinical signs in the neonatal period.5,7 But this association is a statistical rather than an invariable one. After an acute perinatal insult some babies will show transient neurological abnormalities and subsequently recover completely. Others, especially those with cerebral malformations dating from early intrauterine life, may appear neurologically normal in the neonatal period but have severe neurological handicap later—a fact which is explicable from what is known of the development of central nervous system functions in early infancy. There is no 15-minute screening test yet developed which would not give a substantial proportion of false negative or positive results. H. F. R. Prechtl,8 who has been a pioneer in this field, now doubts the value of such a screening examination.

The evidence about the results of very early treatment of cerebral palsy is not altogether clear9,10 because of the absence of controlled trials and because some children who in the early months appear to show signs of cerebral palsy will subsequently have no disorder11—whether or not they are given physiotherapy. Notwithstanding these doubts, most experts strongly recommend that physiotherapy should be started in the first year of life for children showing signs of cerebral palsy to facilitate the development of postural control and movement and to prevent secondary deformities.

It is now widely accepted that all children should have periodic developmental screening tests beginning at, say, 6 weeks, 6 months, and 10 months. Clear and practicable schemes have been devised for doing these tests,12 13 and general practitioners and medical officers in infant welfare clinics are becoming increasingly skilled and enthusiastic in carrying them out. Most cases of cerebral palsy can be detected by 6 months because of developmental delay. This seems a reasonable age at which to start physical management and making plans for the future. The report suggests that the neonatal period may be a more sensitive time for detecting neurological abnormalities than certain later times, and this is sometimes true; but it is hard to believe that anyone would "treat" a baby who was neurologically suspect in the first week but was developmentally normal at 6 weeks and 6 months.

A 15-minute neurological examination on each of approximately 900,000 liveborn babies each year in the United Kingdom would require 225,000 doctor-hours per year. Details of the examination proposed were not given in the report, but it would presumably need to be done by a doctor with considerable experience of the newborn and not by relatively junior staff. There are about 400 consultant paediatricians and about 80 senior paediatric registrars in Britain; they would each have to devote on average about 470 hours per year to this task, or about one-fifth of their routine working time. (Of course, this calculation is only the roughest approximation, but it gives some idea of the magnitude of the task.) Only the most unequivocal evidence of the reliability and value of the neonatal screening procedure could justify such an expenditure of time; many paediatricians genuinely committed to the care of handicapped children will feel they would use their time better in improving the local standard of developmental screening and in providing services for children with actual handicaps.

The prognostic significance of neonatal neurological signs deserves further study, and a reliable and useful screening examination may be found. But for the present this is more suitably the subject for a research project among the babies of a particular community than of a nationwide programme of action. Moreover, it would be a pity if one controversial recommendation diverted attention from the many valuable points made by this report and from the value of universal periodic developmental assessment.

Clinical Direction?

A circular1 was sent last month to the proprietors of private nursing homes approved under the Abortion Act 1967, setting out assurances which the Secretary of State for Health and Social Services required if approval of the home was to be continued. No doubt the Secretary's intention was to curb some of the abuses that have become apparent in the running of some of these homes, and his insistence that there should be adequate arrangements for obtaining blood tests that "outing" for patients will lead to withdrawal of approval is welcome.

The circular also states that “The Secretary of State is advised that it is highly desirable that a woman should not be discharged on the same day as that on which her pregnancy has been terminated. It should be explained to each patient that the overnight stay is in the interests of her health and she should be given every encouragement to stay.” This advice seems to ignore reports2 3 of the safety of vacuum aspiration as an outpatient technique for abortion. Surely it is the responsibility of the gynaecologist carrying out the termination to decide which procedure to use and whether or not overnight admission is necessary in any particular case. The circular also requires that the number of terminations carried out in a 24-hour-period is not to exceed the number of beds specified in the application for approval of the home, and the Department's intention seems to be to avert a situation in which women who need retaining in the home are sent away because there is no bed available.

But it is no solution to fetter professional judgement by laying down guidelines of clinical practice, and a decision on when a patient is fit to be discharged is clearly a clinical judgement. Direction of this kind would not be accepted within the N.H.S.—and it is no more acceptable in an admittedly sometimes shabby section of the private sector.

1 Department of Health and Social Security, E/A223/8, 18 October 1971.