ceutical profession and the Social Services Department took effect in January.

The agreement takes account of the substantially higher operating costs of smaller pharmacies, many of which have been forced to close in recent years.

CORRECTION

We apologize that the word 'skill' was omitted from the first sentence of the final paragraph of Dr Thirlwall's letter on page 697 of the November issue. This should have read: "The nub of the argument for general-practitioner units is combining a relaxed and familiar ambience for delivery with immediately available skill and equipment".

LETTERS TO THE EDITOR

PRE-SCHOOL DEVELOPMENT SCREENING

Sir,

I was interested in the letter from Dr P. Rowlands (November *Journal,* p.698) on the subject of pre-school development screening.

I am a strong supporter also of many of the Court recommendations, and feel that pre-school development screening should be in the hands of general practitioners, and that the child welfare clinics have outlived their usefulness.

I do feel I must issue a word of warning to all those contemplating starting such clinics. We must make sure of an item-of-service payment for such screening. The Department of Health and Social Security would be delighted for us to take on this task without such an undertaking, and with our present open-ended contract this could well happen by default.

We are living through difficult financial times, and we must not take on additional work without adequate remuneration.

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Reference

Court Committee (1976). *Fit for the Future.* Report of the Committee on Child Health Services. Cmnd 6684. London: HMSO.

Sir,

I am sorry that Dr Rowlands (November *Journal,* p. 698) interprets my article on attendance rates at a pre-school development screening clinic (July *Journal,* p.428) as a threat to the motivation and enthusiasm of the many family doctors who organize similar clinics with satisfactory attendance rates. However, I make no apologies for reporting a programme with high default rates as we are unlikely to make progress in health care if we report only our successes.

Although universal child screening is an attractive concept, review of the literature reveals little research to evaluate this approach and selective screening was discussed not to advocate it but to suggest that we maintain an open mind as to the best means of identifying childhood problems as soon as possible. Individual doctors and groups of doctors should of course implement preventive care of children as they see fit, but those responsible for giving total medical care have a duty to provide clearer guidelines on the basis of more extensive research.

I am somewhat confused by Dr Rowlands' questions about assessment since, as clearly indicated in the title and text of my article, the results related to a screening programme. I am sure Dr Rowlands is aware of the important and fundamental differences between developmental screening and assessment. The details of this programme were not reported in the article as I referred to an earlier published article which gave this information.

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Sir,

In a report from the Department of Community Medicine, University of Glasgow (July *Journal,* p. 428), Drs Freer and Ogunmuyiwa commented on the problem of non-attendance for pre-school development screening in a health centre.

By contrast, in our group practice of approximately 12,000 patients in the south of England, the attendance rate is 100 per cent at six weeks and 98 per cent at eight to ten months. Developmental paediatric assessment was started by Dr Pauline K. Keating, Senior Assistant Medical Officer, and Mrs J. Price, Health Visitor, in 1969 with the full co-operation of the general practitioners and staff on the practice premises.

In 1969 children were screened at six weeks, ten months, two years, three years, and four and a half years. The regime has since been modified. Children are now examined at six weeks, eight to ten months, and four and a half years by a senior clinical medical officer and the attached practice health visitor. The two-year and three-year assessment is undertaken by the attached practice health visitor in the home. On completion of assessment the mother and the health visitor decide whether any part of the assessment deviates from the normal. The child is then given an appointment within a month for assessment by the senior clinical medical officer (Fisher and Keating, 1973).

Health education is fully implemented and each mother is made aware at the antenatal stage of the examinations what her unborn child could receive at a later date. Children readily attend from differing social classes and backgrounds. Problem families, child-abuse register children, and children from middle and low social classes are all eager to avail themselves of the caring service offered to them.

If a child defaults the mother usually sends an apology. The child is then offered an alternative appointment within the next month. Second defaulters are followed up at home, reasons established, and if necessary the health visitor will make an assessment during her domiciliary visit.

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