concept of triage in accident and emergency. Triage alone cannot alter waiting times. The word means "to sort"—in this context according to priority. It does not reduce in any way the amount of medical work to be done; it alters the order in which it is done. Waiting times will indeed be reduced for more seriously ill patients, but only at the expense of longer waiting times for people with less serious problems.

Medical workload and hence waiting times can be reduced only if triage nurses take on additional responsibilities, such as initiating radiography or other investigations, referring patients elsewhere, or undertaking the treatment of some of the patients themselves. The role then becomes that of a nurse practitioner, an entirely different concept.

It is absurd to suggest that triage can be provided intermittently. Only the quietest of accident and emergency departments can be run without prioritising attendances, whether this is formally designated as triage or not.

It is equally misleading to suggest that triage can meet the requirements of the patient's charter. The charter demands that patients are seen immediately. Pressed to define this, the Department of Health has said it should mean "an immediate visual assessment." Accurate triage cannot be done by looking at someone, and establishing the minimum data needed to prioritise a patient accurately takes an average of five minutes in my experience. While triage nurses are assessing one patient they clearly cannot simultaneously assess the other patients who arrive during this period.

Triage is a valuable tool in the efficient running of any department that is overworked and understaffed, as most accident and emergency departments in Britain are. It is not the solution that the government seeks to cut waiting times and meet ill conceived promises to the general public. Keighley and Maycock do at least recognise the need for additional staff and attention to departmental layout. The Department of Health unfortunately demands that we introduce immediate assessment entirely within existing staffing levels. This will inevitably increase waiting times for actual nursing care and treatment. Perhaps triage should be seen as part of the problem, not part of the answer.

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Nurse practitioners in accident and emergency departments

EDITOR,—Susan M Read and colleagues provide an interesting insight into the current practice of nurse practitioners in accident and emergency departments in England and Wales.[1] It is not clear, however, that they attempted to ensure that a nurse practitioner was actually on duty on the two days chosen for their study. Their results must therefore be extrapolated with caution. The caseload on any particular day varies enormously. For example, in our department on the two days in question 21·2% and 1·8% of patients were seen by a nurse practitioner. For 1992 this equated to 4·45% (2519) of all patients.

Our nurse practitioner works completely separately from nurse triage but carries out other functions: educating patients, teaching, and explaining the scheme to visitors. These additional roles are just as important as the clinical ones. We also believe that nurse practitioners should work occasional shifts in their previous nursing role in the department to help maintain their all round experience.

The authors state that the volume and range of work performed by nurse practitioners are small. Although in relative terms the percentage volume may seem small, 2519 patients a year, as in our case, is not insignificant, and the range of work will undoubtedly expand. We must emphasise, however, that the object is not to create a substitute for the senior house officer but to improve the quality of care that the department provides to its patients. This is achieved by spreading the workload at certain peak periods and by reducing the waiting times for patients with relatively minor problems.

The position of nurse practitioner provides an opportunity for nursing staff to broaden their professional practice and to forge an invaluable link between medical and nursing staff. With a validated training programme, clear guidelines, and regular audit, nurse practitioners have much to offer in the development of accident and emergency medicine.

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Screening, ethics, and the law

EDITOR,—In their editorial on screening, ethics, and the law P J Edwards and D M B Hall recommend that screening programmes should meet three criteria.[1] If "treatment at the presymptomatic stage should favourably influence outcome," however, prenatal screening, carrier screening for recessive diseases, and screening for untreatable disorders in the newborn period would be precluded. Though the case for such programmes needs to be argued carefully, they should not be ruled out.

Newborn screening for Duchenne muscular dystrophy may benefit the family of the identified child. Affected boys are identified several years earlier, and their families can be offered reproductive choice in future pregnancies and practical and emotional planning for the future. Studies indicate that most parents of affected boys would like to have been offered newborn screening[2] and that most mothers would request such screening.[3] Supported by the Muscular Dystrophy Group of Great Britain, we are evaluating a pilot programme of newborn screening for Duchenne muscular dystrophy in Wales. This includes a social evaluation: are the potential benefits experienced as such by the families? Our preliminary experience will be reported in this journal.[4]

In commenting on the editorial, Nicholas Wald and Malcolm Law claim that providing information concerning false positive and false negative rates in antenatal serum screening programmes is inappropriate. Similarly, they would not inform women about the risks of amniocentesis at entry to a programme, only after a positive result of serum screening.[5] Is it reasonable to assume that women can make an informed decision about serum screening if such information is withheld?

Pregnant women should be given maximum information, orally and in writing, and made aware that screening is an option and not an obligation. For example, women involved in the maternal serum screening described by Wald and colleagues[6] should know that the detection rate is less than 50%, the positive predictive value is 2·3%, and amniocentesis carries a risk of miscarriage, which depends on the operator.

We are concerned that prenatal serum screening will be introduced into routine service without proper social evaluation (we are not aware of any published studies on this) and without scrutiny from local research ethics committees. The motivation underlying this haste may be the desire to improve the "genetic health" of the population, but this could be at the expense of people caught up in such programmes. This possible conflict was discussed by Harper, who expressed concern that "the subordination of individual decisions to broader population based goals" has great potential for causing harm.[7] This may damage our clients and bring genetics once again into disrepute.

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Whistle blowing

EDITOR,—"Once a newspaper touches a story, the facts are lost forever, even to the protagonists."[1] *World Medicine* could not have found a more apt quotation to head a prophecy about the devastating effect on the morale of hospitals and the public that was likely to follow media criticism of a psychiatric institution in 1984 (an epidemic of salmonellosis had led to deaths.) For weeks knives were being honed and political axes ground. As in the controversy over interleukin 2 at the Christie Hospital[2] and the current affair concerning Helen Zeitlin,[3-5] the public thought that they had the facts; they had selected facts.

In his perceptive editorial Richard Smith shows that going public has a dark side.[2] Not only is it "a curse on ineffective organisations": having gone public, the doctor has lost control of the outcome. "The press is too ready to crucify a hospital," wrote *World Medicine*. "Overnight, a patient's confidence in the place, years in the making, can be lost forever. Hyde does not have to imagine—for he was there—the purgatory of bitterness, shame, despair, and self-reproach when things went terribly wrong in his own hospital, despite timely, clear, and specific warnings to authority from his colleagues ('shroudwaving'). He does not need television and newspapers to remind him or point the moral."[1] Management by the media is hopeless and publicity almost totally counterproductive.[2]

World Medicine was talking about shroudwaving as distinct from whistle blowing. Shroudwaving is well understood in the NHS by those who conduct it (hospital consultants) and those who condemn it (the Department of Health). The game has strict rules—official channels, as they are called—and is played to narrow the gap between what medicine can do and what the NHS can fund. Only when the official channels have failed is it admissible to resort to whistle blowing. In the Zeitlin imbroglio, in which, on the face of it, a doctor seems to have gone public without first securing a power base, the questions are simple: had the official channels failed? Had they been tried? Was there a hidden agenda? Why has there been a studious silence