applied widely we assumed that regional clinical genetics departments and those who care for people with cystic fibrosis, including general practitioners, would cooperate. We are confident that our counselling and that which individuals and couples would receive in other clinical genetics departments in Britain would be the same, and we are therefore happy to recommend widespread application of screening.

We accept that cascade screening will detect only about a quarter of carrier couples, as D J H Brock points out.[2] These "islands" of carriers and carrier couples are, however, easily accessible as a person with cystic fibrosis or a carrier is at the islands' centre and knowledge of the disorder is high among the people concerned. Whatever screening programmes health authorities introduce, cascade screening should be the starting point until the public starts to request population screening programmes, as Sandy Raeburn suggests as the ideal.[3] The uptake of prenatal diagnosis per detected carrier couple will naturally be higher in Brock's screening programme than ours if Brock starts by offering the test in pregnancy. Most of the women in the carrier couples were not pregnant when our screening detected them; when pregnancy occurred only one declined tests. We do not think that the "sick family" syndrome is likely with the commonest autosomal recessive disorder, as Nadeem Quereshi claims.[4] It is easy to reassure carriers who are detected that everyone carries a few recessive genes.

No one (except perhaps Marteau) believes that relatives should not be offered carrier screening. The only question that then remains is whether promotion of an active testing programme in relatives infringes their basic right not to know whether they are a carrier; we submit that it does not. Ideally we would like tests to be available for those who ask for them, whether relatives or not, with active promotion no longer necessary.[5] This will be possible only when public awareness, even among relatives, is far greater than it is now. We hope that more people will now enter this debate.

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Screening in primary care is preferable

EDITOR,—We agree with the stance taken by Julian D A Cooper and Antony J Franks and by Nadeem Quereshi in response to the debate about population screening for carriers of the cystic fibrosis gene.[1,2] We found in a survey that the general public is interested in becoming involved with the issues and showed a clear preference for screening to be offered through primary care.[3]

When we offered carrier testing with other health promotion through a prepregnancy care clinic in one general practice, although attendance was low (about 1% of patients of reproductive age), interest in screening was high among participants (16/18 (89%)) and to date 10 of the 18 participants (55%) have been tested. A feature of this model was the variable length of time between learning about carrier screening and actually requesting the test—several months in some cases. The preconception approach is complementary to screening in pregnancy and will overlap with it. Although uptake may be small, assimilation of the implications of the test will be enhanced in the antenatal period.

Quereshi notes the need for adequate professional education if screening were to take in primary care.[2] With general practices increasingly finding it necessary to focus on activities that generate the highest income in the short term, there is little motivation to undertake many aspects of preventive health. So long as screening for genetic disorders retains its current low profile with purchasing authorities, efforts by specialist genetic centres to provide the background training and support for primary care will be wasted. We recently surveyed the 12 general practices in north Newcastle for their reaction to a proposal to develop genetic services in the community with the offer of appropriate staff support in a collaborative pilot project. Only two practices were clearly in favour. Most of the others were not in favour on the grounds of lack of time and adequate reimbursement rather than disagreement with the principles entailed.

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Audit improves neonatal (Guthrie) screening programme

EDITOR,—We conducted an audit of the neonatal screening programme for phenylketonuria and congenital hypothyroidism in the Northern region in 1993. Like Allison Streetly and colleagues, who looked at screening in south London,[1] we found that arrangements for monitoring the existing screening programmes were inadequate, though we do not have London's problems regarding mobility of families and we have a smaller proportion of people from ethnic groups than the London areas.[1] We found that in five of the districts no satisfactory mechanisms existed for checking that each baby had been screened and that in five of the 11 districts that make checks an inappropriate delay (several weeks) in checking could occur. Only six of the 16 districts had a timely failsafe mechanism in place for ensuring that all babies were screened. In addition only one district was confident that its coverage was 100%; other districts did not routinely monitor their coverage.

After the audit, information was fed back to each district with suggestions on how the screening programme could be improved. Six months later all districts except two had a timely failsafe mechanism for identifying babies who had not been screened. We agree with Streetly and colleagues that monitoring of coverage is essential and that explicit standards need to be set.[1] In our experience, audit has been a useful mechanism for reviewing the neonatal screening programme and has resulted in changes in most districts to improve the monitoring of the programme.

The audit was carried out with a grant from Northern Regional Health Authority.

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Two tier system for outpatient treatment

EDITOR,—For the second time a fundholding practice has referred a patient to me with a request for a consultation only. I understand that this means that the practice pays about £30 for the privilege of seeing me, but I am not allowed to do any investigations or obtain any *x* ray films. I am allowed only to see the patient and express an opinion.

Where does responsibility for the patient lie? If the problem is, say, backache, the *x* ray films are either inadequate or inappropriate, and I am concerned that there is a tumour and believe that further investigations are required, what do I do? The current system seems to be that I write to the general practitioner and pass the ball back into his or her court. If the general practitioner decides to take no action where does the responsibility lie? If the general practitioner decides that further investigations are required the patient has yet another trip to hospital. If the general practitioner does not act on the consultant's advice and a problem arises the consultant, in my view, has failed in his or her duty to the patient.

There already seems to be a two tier system for inpatient treatment and there may well be one for outpatient treatment too, which would operate to the financial advantage of fundholding general practitioners but, I suspect, to the disadvantage of patients.

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Waiting times in an ophthalmic outpatient department

EDITOR,—A M Ansons and colleagues describe some of the problems that a busy academic eye department is experiencing in meeting the patient's charter.[1] At around the time of the charter's introduction we conducted a survey of ophthalmic outpatient services in a district general hospital with three consultants and serving 250 000 people. Information was collected by six management students, who obtained details of 393 (95%) of the 414 patients attending clinics during one week.

Overall, 116 patients were seen by a consultant, 58 by the registrar, 190 by one of the three senior house officers, and 50 by one of the general practitioner clinical assistants. The clinics were usually fully booked but had an additional daily workload of between one and 15 unbooked patients (referrals from the accident and emergency department and urgent referrals from general practitioners) added to them. The senior house officers ran a daily casualty clinic but sought advice from a consultant or the registrar concerning 79 patients. Sixty six patients arrived later than their booked appointment (usually because of transport problems) and had to be fitted into the clinic out of