

1. National statement on ethical conduct in research involving humans. Canberra: National Health and Medical Research Council, 1999. <http://www.nhmrc.gov.au/publications/pdf/e35.pdf>. □

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COMMENT: As I understand Carapetis et al's study, the researchers determine who has a group A streptococcal infection from the laboratory that performs the test (as this infection is not a notifiable disease,¹ there is no central source of information). The laboratory may be independent or in a public or private hospital, and may be situated anywhere in Victoria. The laboratory tells them who requested the test and the patient's name and infection status. The researchers then seek assistance from the hospital or doctor requesting the test in obtaining "individual informed consent" from the patient to release clinical information to the researchers. Each institution has required that its own human research ethics committee approve the project, as well as the Department of Human Services (DHS) Ethics Committee, before the laboratory releases information. This accords with the law, but the additional bureaucracy and costs involved will deter much important public health research.

The law: In Victoria, public and private hospitals and their employees have a statutory duty of confidentiality under section 141 of the *Health Services Act 1988* (Vic). There is an exception when the patient consents (s 141(3)(a)), but, in Carapetis et al's study, patients cannot be approached until the laboratory gives identifying information. Information may be divulged for medical research without patient consent if an ethics committee "established under the by-laws of the agency" has approved "the use to which the information will be put and the research methodology" (s 141(3)(g)). The giving of information must also accord with Health Privacy Principle (HPP) 2.2(g) in the *Health Records Act 2001* (Vic): it must be necessary and "in the public interest"; it is impracticable to seek consent; identifying information is needed; identifying information will not be published; and it must conform with the Guidelines of the Health Services Commissioner.² The federal *Privacy Act 1988* (Cwlth) contains similar provisions.³

Options for change: The Health Services Commissioner has power to issue guidelines varying the subparagraphs of HPP 2, and even to lessen the level of privacy protection, if it is in the public interest to do so.⁴

However, guidelines cannot override the requirement in the Health Services Act that projects must be approved by the ethics committee "established under the by-laws of [each] agency". There are four options for change:

■ The Health Services Act could be amended so that approval of *one* human research ethics committee is sufficient.

■ The Secretary of the DHS could prescribe more diseases as notifiable,¹ so that information is available centrally, and access could be authorised by the DHS Ethics Committee.

■ The Secretary could request information from pathology laboratories for public health research and supply that to the researchers (laboratories would be protected under section 137 of the *Health Act 1958* [Vic]).

■ Institutions could amend their by-laws — or ethics committees could adopt a policy — that the institution will follow the approval of the DHS Ethics Committee in public health research.⁵

The last seems the simplest option, but historically this approach has not been favoured in multicentre trials in Australia.

1. Health (Infectious Diseases) Regulations 2001 (Vic) reg 6, scheds 3, 6.
2. *Health Records Act 2001* (Vic) s 141(3)(g)(iii). Sched 1, Health Privacy Principle (HPP) 2.2(g).
3. National Health and Medical Research Council. Guidelines approved under Section 95A of the *Privacy Act 1988*. Canberra: NHMRC, 2001. Available at <<http://www.nhmrc.gov.au/publications/synopses/e43syn.htm>>
4. *Health Records Act 2001* (Vic) s 22(1)(a)(5).
5. Tully J, Ninis N, Booy R, Viner R. The new system of review by multicentre research ethics committees: prospective study. *BMJ* 2000; 320: 1179-1182. □

Opportunistic screening for type 2 diabetes mellitus in public hospitals

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TO THE EDITOR: Diabetes is a leading cause of morbidity and mortality in Australia, with 50% of cases remaining undiagnosed.¹ Consequently, the Australian National Diabetes Strategy has early detection of diabetes as a key priority.² We undertook a study to determine the prevalence of abnormal glucose metabolism (impaired fasting glycaemia [IFG] and diabetes) in patients presenting in the fasted state for endoscopy or colonoscopy at a metropolitan teaching hospital. We used the

Results of fasting plasma glucose tests in 224 patients presenting for gastroenterological procedures

Fasting plasma glucose level

Normal (<6.1 mmol/L)	172 (77%)
Impaired fasting glycaemia (≥6.1 mmol/L, <7.0 mmol/L)	22 (10%)*
Diabetes (≥7.0 mmol/L)	6 (3%) [†]
Not tested (known diabetes)	24 (11%)

*Diabetes was confirmed on subsequent oral glucose tolerance test (OGTT) in nine of these patients (four refused further testing).

[†]Diabetes was confirmed on subsequent OGTT in all six patients.

definitions of abnormal glucose metabolism outlined by the World Health Organization in 1999³ and published in a position statement in the *Journal* in April 1999.⁴

Two hundred and twenty-four patients gave informed consent and participated in the study, comprising 126 men and 98 women. Mean age (SD) was 75.1 years (6.9) for men and 60.9 years (17.6) for women. Twenty-four participants (11%) had known diabetes. The remaining 200 patients had fasting venous plasma glucose levels determined (Box). Patients with abnormal glucose metabolism (fasting plasma glucose level >6.1 mmol/L) were offered further testing with a 2-hour oral glucose tolerance test (OGTT) after a 75 g glucose load. Nine patients initially classified with IFG had diabetes based on OGTT results. No patient classified with diabetes on initial testing was subsequently classified as not having diabetes by the OGTT. The overall prevalence of undiagnosed diabetes was 7% (15 patients).

We demonstrated a high prevalence of abnormal glucose metabolism in a group of predominantly elderly patients presenting for gastroenterological procedures. Furthermore, subsequent investigation of these patients revealed that a substantial proportion who were classified with IFG on initial screening were classified with diabetes based on 2-hour OGTT results, highlighting the importance of this test in diagnosing diabetes.

It is likely that we underestimated the prevalence of abnormal glucose metabolism, as OGTT was not performed in all patients. This is supported by results of the AusDiab study that revealed a high prevalence of abnormal glucose metabolism in older patients — 37% of those aged 55–64 years, 47% of those 65–74 years, and 53% of those 75 years and over.¹ National Health and Medical Research Council guidelines suggest that all patients with a fasting plasma glucose level of 5.5–6.9 mmol/L be