We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

EVALUATING DIAGNOSTIC TESTS

Selecting tests for evaluation

Walley outlines some of the problems encountered in evaluating laboratory diagnostic tests.[1] One of the great difficulties faced by organisations such as the National Institute for Health and Clinical Excellence (NICE) is to find a means to prioritise diagnostic technologies for rapid evaluation. I have recently developed the following prioritisation criteria for use by organisations.

The disease

- Can the disease be clearly defined?
- Is the condition an important problem in terms of prevalence and incidence or morbidity and mortality?
- Is it a policy priority?
- Does the condition present a diagnostic problem (inaccuracy or inefficiency), and would it be useful to have better diagnostic tools?
- Is there evidence of current variation in diagnostic practice (or inappropriate variations in treatment, morbidity, or mortality resulting from diagnostic variability)?
- Could the diagnostic processing pathway for the disease be improved by obtaining information in a less risky fashion or in a manner more acceptable to patients?

The diagnostic technology (history and examination, physiological measurement, imaging, endoscopy, pathology)

- Is there clarity about the purposes and the costs of this technology in the context of a diagnostic processing pathway?
- Has the safety and analytical validity been established, and is it CE marked?
- Is there evidence of clinical validity in the appropriate setting?
- Are there opportunities for enhanced efficiency or cost savings in relation to the current diagnostic processing pathway if this technology were more widely employed?
- In the absence of an appraisal, is there any likelihood of "drift" with overuse or inappropriate use of this technology?
- Is it feasible to change current practice to incorporate this technology (for example, by considering additional requirements for training, infrastructure, and quality control)?

The impact of the diagnostic technology

- Is there an effective treatment for the target condition, and could greater diagnostic precision using the technology lead to better targeted treatment delivery?
- Is there an effective treatment for the target condition, and could more rapid diagnosis using the technology lead to shorter treatment delays?
- Would better diagnosis result in lowered morbidity and mortality both from the disease and from the diagnostic process?

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Competing interests: NS is currently undertaking a review for NICE on the institute's approach to diagnostic technology evaluation.

1 Whalley T. Evaluating laboratory diagnostic tests. *BMJ* 2008;336:569.

VERY TIGHT GLUCOSE CONTROL

May be high risk, low benefit

The problems with a glucocentric approach to managing patients with type 2 diabetes[1-3] can be seen using data from the UKPDS.[4] In the 10 years of follow-up of newly diagnosed patients with a mean age of 53, macrovascular events (myocardial infarction and stroke) were five times more common than serious microvascular events (blindness in one eye and renal failure) but, unlike these, were not significantly reduced by intensive glucose lowering. Moreover the observational data from the study[2] showed a substantially less steep relation of mean concentrations of HbA_{1c} levels over 10 years with macrovascular risk than with microvascular risk. These data imply that if glycaemia per se has a role in the aetiology of macroangiopathy, the maximal potential benefit from a 1% reduction in HbA_{1c} is 14% for myocardial infarction and 12% for stroke. Intervention studies with statins and antihypertensives have shown benefits of around twice these amounts.[5] A qualitative difference for the patient also exists between regimens based on tablets and those based on injections (perhaps multiple) and blood glucose monitoring, as well as the additional risk of hypoglycaemia.

The other value of UKPDS data is the possibility of calculating numbers needed to treat. In that study, the 10 year risk of macrovascular disease was 22%, around four times that of the control group in the ACCORD study.[1] If this figure is combined with the epidemiological data,[2] the maximal potential benefit of lowering HbA_{1c} by 1% in a 53 year old patient with type 2 diabetes would be a reduction of 3.1% over 10 years (14% of 22%). This implies that for every 32 people treated for 10 years with an intensive glucose lowering regimen, at least 31 would have exactly the same outcome, whether or not they were using the regimen. While absolute cardiovascular risk, and so potential benefit, increases with age, the same is true for the potential risks of adverse consequences of hypoglycaemia.

One hopes that the ACCORD study will inject a note of caution before conflating blood glucose with cholesterol and blood pressure as cardiovascular risk factors worthy of aggressive intervention. Even if ADVANCE and other intensive glucose lowering trials prove positive, informed choice should require that patients be provided with full explanations of the likely level of benefit expressed as absolute, and not relative, risk reduction.

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1 Home P. Safety of very tight blood glucose control in type 2 diabetes. *BMJ* 2008; 336: 458-9. (1 March.)
2 Stratton IM, Adler AI, Neil HAW, Matthews DR, Manley SE, Cull CA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ* 2000;321:405-12.
3 Gerstein HC and Yusuf S. Dysglycaemia and risk of cardiovascular disease. *Lancet* 1996;347:949-50.
4 UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). *Lancet* 1998;352:837-53.
5 Cholesterol Treatment Trialists' (CTT) Collaborators, Kearney PM, Blackwell L, Collins R, Keech A, Simes J, Peto R, et al. Efficacy of cholesterol-lowering therapy in 18,686 people with diabetes in 14 randomised trials of statins: a meta-analysis. *Lancet* 2008;371:117-25.

REFUSED ASYLUM SEEKERS

Seeking medical justice

With reference to Heath,[1] existing secondary care restrictions have already contributed to avoidable deaths among failed asylum seekers.[1 2] There is no evidence that they have saved money, except perhaps by deterring people who are still entitled to care from seeking it. Removing the right of general practitioners to register failed asylum seekers will extend the damage to individual and public health and the ethos of our profession. These steps will not

produce economies or make these patients "go home," even though government openly intends to use denial of care to coerce their involuntary departure. They will require doctors to act as immigration police.

If the state forbids us to investigate, treat, and refer certain patients on public funds, we can still examine, document, and advise about their medical conditions. We can also inform ministers and the public of the consequences of these policies. That is the commitment made by over 600 doctors who have signed a petition, Medical Justice for Undocumented Migrants.[3] The petition is still open to signatures, and a form letter to document and publicise the consequence of denial of care[4] is available online.

Our actions are completely lawful but are unlikely to find favour with our masters. They may also lead to retribution (see competing interests). Many of us believe that the BMA (and the General Medical Council and royal colleges) have an obligation to offer practical guidance and protection to doctors who put their duties to patients ahead of government blandishments, and that these bodies have not yet fulfilled it. It would also help if the *BMJ* could—as a service to evidence based policy making—accept, collate, and publish analyses of the consequences of these immodest and thoughtless policies.

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Competing interests: FWA was reported to the GMC for providing potentially lifesaving medical advice to three "failed" asylum seekers on hunger strike in an immigration detention centre, by the managers of that centre. The GMC eventually held that doing so does not violate the duties of a doctor. These patients made a good recovery and were released from detention because of legitimate appeals against the original judicial decisions that labelled them as "failed".

1 Heath I. A modest thoughtfulness. *BMJ* 2008;336:535. (8 March.)
2 Morris S, Allison E. Hospital defends treatment in asylum seeker death. *Guardian* 2008 13 Feb. www.guardian.co.uk/society/2008/feb/13/nhs.immigrationandpublicservices
3 Medical Justice for Asylum Seekers. www.gopetition.co.uk/petitions/medical-justice-for-asylum-seekers.html
4 Medical Justice. Government proposals to withdraw free primary healthcare. www.medicaljustice.org.uk/content/view/319/100/.

Impractical and unjust

No matter where you stand on immigration, I find it hard to see how denying primary care to a person can be compatible with being a doctor.[1] Credit to Iona Heath, and also Frank Arnold, for highlighting this looming injustice. Fairly recently, a politician also highlighted that a policy of excluding "illegals" is as impractical as it is unjust:

"One of the consequences of the universality of the British health service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free health service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the health service any more than does a British citizen. However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the health service for ourselves would end by being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march together." The politician was Aneurin Bevan, speaking in 1952.[2]

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Competing interests: None declared.

1 Heath I. A modest thoughtfulness. *BMJ* 2008;336:535. (8 March.)
2 Bevan A. *In place of fear*. London: Heineman, 1952.

CABIN FEVER

"Most experts agree"

Despite the emergence of evidence based medicine, so called expert consensus continues to be used to perpetuate myths, in this case that the frequency of inflight medical emergencies is rising.[1]

Data from airline cabin crew reports show wide variation because of differing reporting processes and thresholds. Passenger demographics may be changing, such that the average age of passengers is increasing, but I know of no robust evidence that this is associated with more inflight medical problems—the current generation may well be fitter and more able to travel than previous generations.

If inflight medical incidents were becoming more common, we would expect to see increasing trends for medical diversions and for deaths. We have examined the data for our airline—British Airways—a global international carrier.

Although medical diversions are increasing as a percentage of the total, this reflects a reduction in other causes, and the frequency of medical diversions has not increased. Similarly, the frequency of the (small) number of deaths that occur during flight each year has not changed.

Clearly, if the total number of passengers continues to rise and the average journey duration increases, the total number of cases is likely to rise. However, other than in the context of the total number of passengers on the aircraft, this "expert" would argue that the chances of encountering an inflight medical incident is low, and there is no evidence that it is increasing.

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Competing interests: None declared.

1 Tonks A. Cabin fever. *BMJ* 2008;336:584. (15 March.)

Practical points

I write with reference to Tonks's article.[1] On three occasions I have been asked to attend another passenger or a crew member on a longhaul flight.

An elderly man collapsed. He spoke no English. I did not realise how anaemic he was until we came in to land; curtains were drawn and it was dark outside. Once he was in daylight the diagnosis was obvious. The

cabin staff had been reluctant to draw the curtains as it was still early morning. I suggest that where possible the curtains are drawn when you are making an assessment. The cabin staff wanted this passenger strapped upright in his seat for landing but I managed to persuade them to lie him on floor against a bulkhead. Even sitting him upright in his seat had caused him to faint.

On two of the occasions when I saw a passenger, the captain of the aircraft discussed the option of diverting the flight, but I did not think it would help. I have always found the cabin staff well trained and helpful. One purser told me that on average, staff dealt with at least one medical problem in every 10 flights.

By the way, the stethoscope in the kit is useless because the background noise from the aircraft's engines drowns out any other sound.

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1 Tonks A. Cabin fever. *BMJ* 2008;336:584. (15 March.)