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

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SPENDING ON HIV

HIV funding: debate misses the point

As one who has lost five out of 11 siblings to HIV, I cannot but be aware of the magnitude of HIV. Though the figures of England and de Lay et al differ,[1 2] the element of relative overspending on HIV compared with other health and social developmental sectors is obvious.

Both miss the crucial point that HIV is the only tropical disease receiving anywhere near Western rates of health funding. The reasons for this include the global nature of HIV, the wages and expenses of expatriate health workers, and the many groups working with HIV in the tropics. England could have argued that the money channelled into HIV should be spent through local national health departments. Some African non-governmental organisations and de Lay et al may argue for the status quo, which has created, in some cases to the detriment of health and governance institutions, parallel institutions as it benefits their causes. England should have presented a breakdown of how the HIV funding is being used. He may find that only a small fraction trickles down to African patients with HIV and that a significant chunk bounces back to the West.[3]

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Competing interests: None declared.

1 England R. Are we spending too much on HIV? *BMJ* 2007;334:344. (17 February.)
2 De Lay P, Greener R, Izazola JA. Are we spending too much on HIV? *BMJ* 2007;334:345. (17 February.)
3 Lwanda J. *Politics, culture and medicine in Malawi: historical continuities and ruptures with special reference to HIV/AIDS*. Zomba: Kachere, 2005.

It's only numbers

Both England and de Lay et al play the numbers game of statistics, economy, and modelling of the future.[1 2] But I guess that none of the authors is HIV positive or a doctor and so can sit safely behind a desk jettisoning numbers to the audience.

HIV, tuberculosis, and malaria are among the greatest killers of the poorest people in the world, claiming about 1 million lives each per annum, or 114 people every hour of every day, disabling the future economies and existence of the poorest nations. Yet, has the world conquered even one of the big three? If a glimmer of hope to save the future deaths came from heavy investment in immune damage from any of the big three, then every penny spent is worth while. To change public attitudes will take decades, unlike the immediate and positive effect of Princess Diana holding the hand of a patient with AIDS before the media. Until then money must be invested in trying to stem the tide of death for today and tomorrow.

"Fiddling while Africa burns" is a common issue, when words from desk jockeys take centre stage and engage debate and not action. No author brings a primary solution to the table, but rather each mildly lambasts world authorities and nation leaders for fiscal mishandling. A weak debate. In the time it has taken you to read this another person has died of AIDS—a fact of life.

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Competing interests: None declared.

1 England R. Are we spending too much on HIV? *BMJ* 2007;334:344. (17 February.)
2 De Lay P, Greener R, Izazola JA. Are we spending too much on HIV? *BMJ* 2007;334:345. (17 February.)

PANDEMIC FLU

Look at all the evidence before stockpiling amantadine

Tsiodras et al propose testing amantadine to see if any benefits could accrue in combination with neuraminidase inhibitors in pandemic flu.[1] The principal attraction seems to be low cost. Although they quote resistance and harms as well as lack of "any demonstrable reduction in transmissibility or pathogenicity," this does not seem to deter them from their proposal.

Had they consulted the Cochrane Library, they would have discovered that amantadine (the only adamantane for which we have a reasonable knowledge base) relieves or suppresses symptoms if taken within 48 h, but it does not prevent infection with influenza A viruses or stop their nasal excretion. This is the key finding in a pandemic as apparently healthy individuals devoid of symptoms and feeling good because they have taken "the pill" would be spreading influenza viruses in the community through contact and droplets. Amantadine suppresses symptoms but not infection, it does not prevent or even diminish the risk of influenza communication, it causes unacceptable harms, resistance to it is widespread and swiftly induced: it is a very dangerous drug, especially in a pandemic.[2]

Would the authors give prophylactic amantadine to essential workers knowing it causes gastrointestinal symptoms (mainly nausea, odds ratio 2.56; 95% confidence interval 1.37 to 4.79) and insomnia and hallucinations (2.54; 1.50 to 4.31) and caused withdrawals from the trials because of adverse events (2.54; 1.60 to 4.06)?[2] Would they give it to ambulance drivers, train conductors, and helicopter pilots?

If pharmacological intervention is required to help contain a pandemic, then neuraminidase inhibitors are far safer and more effective than adamantanes.[3] No benefit, but a lot of harm will accrue with continued use of amantadine. That is what all available comparative evidence shows.

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Competing interests: TJ is the first author of both relevant Cochrane reviews. He holds no stock or shares and has not received any fees in the past five years from any organisation which could benefit or be harmed by this letter.

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WHO FUNDING

World Health Organization refutes allegations

The World Health Organization categorically rejects the allegations made in a recent story in the *BMJ* which imply that WHO solicits money from the pharmaceutical sector through independent organisations by circumventing its own rules.[1]

As the *BMJ* correctly reports, WHO has clear guidelines against seeking or accepting funds from commercial enterprises or through third parties where there would be a conflict of interest.

When WHO does accept donations or funds from pharmaceutical companies—for example, donations of vaccines or medicines—those donations are clearly accounted for and transparently reported.

In this specific case, Dr Benedetto Saraceno was very clear. He had never asked that funds be solicited from the pharmaceutical sector, and he declined the funds that were offered.

WHO is concerned about the *BMJ*'s depiction of Dr Saraceno. He is a professional of deep personal integrity. In the 10 years he has been with WHO, Dr Saraceno has tirelessly worked to highlight the public health consequences and grave inequalities faced by the millions of people who are affected by mental, neurological, or behavioural disorders.

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1 Day M. Who's funding WHO? *BMJ* 2007;334:338-40. (17 February.)

RANDOMISED TRIALS

The urge to sprinkle statistics is irresistible

We might be forgiven for believing that Glasziou et al had discovered some hitherto unknown method of causal inference.[1] Instead they have merely stumbled across the way in which causes have been identified in everyday life and science throughout history.[2]

The "mother's kiss" technique for removing a bead lodged in a nostril is an effective treatment not only because it has been shown to work in case reports but also because it is grounded in elementary principles of physics familiar to every child who has played with a pea shooter. It does not need statistical analysis. Yet, the authors—unable to free themselves of the urge to season the data with a sprinkle of relative risks or P values—neglect the fact that the many examples they provide of treatments with clearly observable effects are widely accepted without the need for statistical tricks.

The obsession with both randomised controlled trials and the statistical approach to causation has clouded the thinking of a generation or more of medical researchers. So much so, that the commonsense notion of causation has been relegated to little more than an afterthought. And this accounts for the dismissive approach to any data not derived from randomised trials. Perhaps, after their damascene conversion, Glasziou et al will campaign for a change in the hierarchy of evidence in favour of data from non-randomised sources.

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Competing interests: None declared.

1 Glasziou P, Chalmers I, Rawlins M, McCulloch P. When are randomised trials unnecessary? Picking signal from noise. *BMJ* 2007;334:349-51. (17 February.)
2 Penston J. *Fiction and fantasy in medical research: the large-scale randomised trial*. London: London Press, 2003.

Beware "Texas sharp shooter" in rate ratios of progression

Glasziou et al's method of calculating rate ratios of progression (stable unchanging condition before *v* change shortly after the intervention) is appealing,[1] but we need to be wary of a "Texas sharp shooter" effect. This effect is usually associated in epidemiology with the problem of interpreting apparent clusters of disease in space, where the geographical unit of analysis may have been chosen post hoc so as to maximise the apparent density of cases as in the joke about a Texan firing bullets into the wall of a barn and then drawing the targets around the bullet holes to show his shooting prowess.

An analogous problem may occur when calculating rate ratios in the manner described in this article, although the sharp shooting is in time, not space. In the mother's kiss, the time period used is 10s, which gives a rate ratio of progression of 1440. Perhaps, however, the bead dislodged after only 8 s, a rate ratio of 1440/0.8=1800. Alternatively, if the bead had taken 15 s to dislodge, the doctor, nurse, and mother might still reasonably have felt that they should take the credit for the happy outcome. You need to make an a priori decision about the post intervention time frame you will use—presumably based on the maximum length of time after the event you are prepared to attribute any improvement to your intervention.

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1 Glasziou P, Chalmers I, Rawlins M, McCulloch P. When are randomised trials unnecessary? Picking signal from noise. *BMJ* 2007;334:349-51. (17 February.)

MORPHINE

Double effect is a myth leading a double life

Kelly Taylor's request to use morphine "to make her unconscious" under the principle of double effect is a puzzling choice.[1]

Evidence over the past 20 years has repeatedly shown that, used correctly, morphine is well tolerated and does not shorten life or hasten death.[2] Its sedative effects wear off quickly, toxic doses can cause distressing agitation, and it has a wide therapeutic range. The Dutch know this and hardly ever use morphine for euthanasia.[3]

Palliative care specialists are not faced with the dilemma of controlling severe pain at the risk of killing the patient: they manage pain with drugs and doses adjusted to each patient, while at the same time helping fear, depression, and spiritual distress. Doctors who act precipitously with high, often intravenous, doses of opioids may do so out of compassionate panic, but they are being misled into bad practice by the continuing promotion of double effect as a real and essential phenomenon in end of life care. Using double effect as a justification for patient assisted suicide and euthanasia on the grounds that it is already being done under the rubric of double effect is not tenable in evidence based medicine.[4]

In end of life care double effect is a myth leading a double life.

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