Letters

Palestine: the assault on health and other war crimes

See Editor's choice and Reviews p 1110

Personal view was one sided and unhelpful

EDITOR—I have lived and worked as a doctor in Israel. I have little sympathy for the government of Ariel Sharon, and I have had the privilege of meeting Yitzhak Rabin, as well as many other Israelis who were and are committed to peace. But I am dismayed by Summerfield's comments and appalled by the *BMJ*'s decision to publish them.[1]

The *BMJ* and Summerfield have to ask themselves two questions.

Firstly, is Summerfield's article a fair portrayal of Israel's approach to the health of Palestinians? In my view it is not. When I worked in Israel we gave world class health care to Palestinian children from Gaza, in an atmosphere of respect and of cultural sensitivity. That continues to this day. By not mentioning Israel's positive contribution to health of Palestinians, Summerfield distorts the truth, with the connivance of the *BMJ*.

Secondly, is the Israeli government so bad that it deserves to be singled out for special mention in this way? I think not. Where are the articles dealing with genocide in Africa, the Middle East, and parts of Asia? Where are the criticisms of doctors who carry out judicial amputations? And where is the balance? Summerfield recites the death toll. But if you were to draw up a league table of which regimes had killed the most Arabs, Israel would be a long way down the list.

Lastly Summerfield conveniently takes an ahistorical approach. In 1948 the UN created the state of Israel. Within hours this was rejected by several Arab nations, who then went to war with Israel, with the stated aim of driving the Jews into the sea. Unfortunately, several of those states retain that ambition.

I would not pretend to know how to solve the problems of the Middle East. But I am very confident that the process of achieving peace is not helped by blaming only the Jews.

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1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)

Only way forward is to open up a dialogue

EDITOR—The personal view by Summerfield is a political diatribe that deserves no place in the *BMJ* or any other medical journal purporting to present facts, not fiction.[1]

Summerfield queries the right of Yoram Blachar, chairman of the Israel Medical Organisation, to be chair of the World Medical Association. He omits to mention that Blachar regularly challenges Israel's defence force on access to medical care.[2] I would be more than happy to see similar protests from senior Palestinian doctors about the misuse of medical facilities by terrorists.

If we're talking about appropriateness and bias, simply look at the stark contrast between the UN's record on condemnation of Israel (regular, supported by all Arab and Muslim states, regardless of any inappropriateness or unfairness) and its rank failure to condemn gross injustices, abuses of human rights, state sanctioned murders and torture in various Arab and Muslim states because such proposals are regularly vetoed as offensive to all Muslim countries. The Security Council lost all credibility when it handed its presidency, for however short a time, to Syria, a country that openly supports terrorist organisations and suicide bombers. For an outstanding critique of the continued bias and institutional antisemitism of the UN, see Anne Bayefsky's speech to the UN.[3]

LARRY TOWELL

Israel is not blameless, but its people and government constantly question and debate all its flaws in a public and democratic manner. Only when such debate and government self reflection start to become routine and allowed among the Palestinians or in neighbouring Arab states will there be a chance for dialogue and progress. While dissent is stifled, democracy non-existent, and self reflection absent, peace is unlikely, and Israel will continue to need to defend itself most rigorously.

The only way forward is to open up a dialogue, to recognise each other's right to self determination and peaceful coexistence. We need to recognise and respect our similar hopes and aspirations—to see each other as individuals and not as "the enemy." Biased, ignorant, misleading articles such as that by Summerfield seek only to perpetuate the conflict and fan the flames of blinkered hatred. Shame on the *BMJ* for publishing such a piece.

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1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)
2 Israel Medical Association. *Dr Blachar voices concerns about medical care in Rafah.* www.ima.org.il/en/inner.asp?n=892&p=-1&Par=-1 (accessed 28 Oct 2004).
3 Bayefsky A. One small step. www.opinionjournal.com/extra/?id=110005245 (accessed 28 Oct 2004).

"But about who's suffering worse—there's no argument"

EDITOR—Few, including those responding on bmj.com, seem to dispute the mortality and morbidity statistics presented by Summerfield.[1] Many respondents, however, dispute how his data should be interpreted.

To my mind, the most eloquent and precise interpretation of the Palestinian disaster was written by Derfner, a Zionist and *Jerusalem Post* feature writer. In March 2004, he wrote: "We can argue with the Palestinians about who's to blame; but about who's suffering worse—there's no argument. They are a destitute nation living in an elaborate prison under the guns of the Israeli army. We are a bourgeois, well-travelled nation that spoils its kids and, while being vulnerable to violent death by terror, is most vulnerable to violent death by traffic accident."[2]

The elegance of Derfner's summation is that it reconciles Summerfield's statistics and the views of his antagonists. The subtext of Derfner's summary is clear. He is asking the question: "Israeli people, forget the rights

and wrongs. Can we, a rich nation exposed to greater threats to our health and welfare than occasional Palestinian violence—justify the daily, hi-tech turkey shoot, and ultimately genocide of the Palestinian people?"

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1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)
2 Derfner L. High school during wartime: daily ed. *Jerusalem Post* 2004 March 4:13.

More heat than light in this debate

Editor—Any mention of the Israeli-Palestinian conflict generates much heated debate.[1] But facts are often absent.

There is much agreement. A majority in both nations agree that Gaza and much of the West Bank are not part of Israel. A minority in Israel claim that much of these territories are part of Israel, but this minority would not extend rights of Israeli citizenship to their 3.8 million non-Jewish inhabitants.

Some correspondents refer to "equipoise," but this is misleading. The two countries do not have equal levels of military strength or wealth. Both do not have equal advantages of functioning economies, democratic institutions, elections, free press, or international support from the world's superpower.

Essentially, one side is a quasi-European country with European-style institutions. The other side is a failed third world state with a level of development among the lowest in the world. Gross domestic product per head in Israel is $19 700 (2003), in the West Bank $800 (2002), and in Gaza $600 (2003).[2] In 2004 Israel received $2160m in US military aid and $580 million from USAID. In 2003 Palestine received $75m in aid from the United States and a total of $1000m in aid from non-US sources (European Union and the Arab world).[3]

Neither are the victims of conflict equally distributed. According to the Israeli Information Center for Human Rights in the Occupied Territories (www.btselem.org/), since September 2000 there have been 3722 deaths, 75% of them Palestinians and 25% Israelis; 604 children have been killed (500 Palestinian and 104 Israeli). Altogether 6709 Israelis and 27 998 Palestinians were injured in the same period.[4 5]

Perhaps the only other facts of relevance are demographic. Israel's current Jewish population is 5.2 million and is predicted to grow at less than 1% per year. Israel's non-Jewish population is 1.3 million and is predicted to grow at over 2% per year. The Palestinian population is 3.8 million, predicted to grow at 3.8% per year (www.prb.org/). In the end, demographic and other forces will oblige some kind of reconciliation between the comparatively well ordered Israeli state and the chaotic exploding population within and outside its borders.

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1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)
2 Central Intelligence Agency. The world factbook 2004. www.cia.gov/cia/publications (accessed 29 Oct 2004).
3 USAID. West Bank and Gaza. www.usaid.gov/policy/budget/cbj2004/asia_near_east/west_bank_gaza.pdf (accessed 28 Oct 2004).
4 Israel Defense Forces. Casualties since 29.09.2000 updated 13.09.2004. www1.idf.il/SIP_STORAGE/DOVER/files/7/21827.doc (accessed 28 Oct 2004).
5 Palestine Red Crescent Society. Table of figures. www.palestinercs.org/crisistables/table_of_figures.htm (accessed 28 Oct 2004).

Summerfield's outrage is misplaced

Editor—Summerfield's jump from psychiatrist to attorney, judge, and jury is a classic example of the inappropriate use of science and medicine to promote specific political views.[1] Any reasonable and objective observer of the longstanding conflict between Arabs and Jews understands that the situation is not as prejudicially simple as Summerfield would have us believe.

His outrageous statement that Israeli soldiers are "Clearly … routinely authorised to shoot to kill children … " is particularly egregious, baseless and something that has no place in a journal where science and evidence is valued. What is in fact routine is the care that Palestinians continue to receive, even today after years of conflict, in Israeli hospitals and from Israeli physicians. Unlike Israeli civilians, who dare not set foot in Palestinian villages for fear of being attacked and killed, Palestinian Arabs receive care in Israel that they could not receive in any neighbouring Arab country. In the last few months alone nearly 200 Palestinian children who were referred under a joint Israeli-Palestinian programme to treat children with serious medical conditions have already undergone major surgery at Israeli hospitals at no cost to the families. Another 350-400 Palestinian children have undergone free diagnostic testing.

It is true that Palestinians have been forced into dreadful conditions because of the continuous policies of their own leadership, but Summerfield would do well to consider how Palestinian actions, rather than Israeli reactions, play a role in this continuing tragedy.

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1 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924. (16 October.)

Personal view from Israel

Editor—As a doctor who has worked in Israel for 10 years, I am astounded that such one sided political views as those of Summerfield could be printed in such a distinguished medical journal.[1] I have spent the past five years working in Ramla—a mixed Arab and Jewish town with a patient list of over 30% Arabs. I have never heard a single complaint from any of my patients that they have been discriminated against in any way by the Israeli medical system because of their colour, religion, or background.

Previously while working in hospitals in Jerusalem, I saw how Arab and Jew are treated side by side, with first class medical services, and no distinctions made between them. Routinely patients from the PA that needed more advanced care than the Palestinian Authority hospitals could give were transferred and treated in Israeli hospitals.

Until I read of the Israeli Medical Association's apparent discrimination in Summerfield's article I didn't realise quite how I have come to take for granted the way that fair and equal treatment of Arab and Jewish Israelis is a given, which no one in Israel even thinks twice about, so I suppose I must thank Summerfield.

I am also a reservist doctor in the Israeli Defence Forces (IDF). I am afraid rather than being "authorised to shoot to kill children" the orders I have received have been more about the sanctity of human life and the need to preserve it even if it is sometimes at the price of endangering soldiers—something many other armies could learn from.

I could move on from a personal view to a more political one, but I don't believe that the *BMJ* is the right forum.

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Summary of responses

Editor—As Britain's daily papers reported Israel's historic vote on withdrawing from the occupied territories, the debate about Summerfield's personal view raged on.[1–3] By 27 October well in excess of 400 responses had been posted on bmj.com, including two from Summerfield providing the detailed sources for his personal view.

The debate started mainly with opposing views, moving on to mainly views in favour and then more of a mixture. Those who were opposed to the article were vehemently so: dangerous diatribe, venomous, and slanderous were just some of the descriptions used. Many of those who may not necessarily have refuted the sentiments expressed in the article objected to what they perceived as the politicisation of a medical and scientific journal, or as the *BMJ* simply being out of its depth. They raised the issues of editorial control and possibly flawed editorial judgment. Some even called for the editor to resign—while others congratulated the editorship on a particularly brave and necessary decision in publishing the article.

Correspondents heatedly and in great detail listed the perceived inaccuracies, omissions, imbalances, and even lies; this consti-

tuted most of the correspondence. Others refuted the comparisons that were drawn with other historical and current political conflicts. Another common theme was the relating of personal experience of many Israelis and people who have worked in Israel.

Several correspondents suspected the *BMJ* of having published the piece to gain hits on the website, insisting it was a poorer journal for having done so. Others also commented that doctors do not have a unique insight into the problem. Still more correspondents pointed out that Summerfield had published his point of view in the *BMJ* on several previous occasions, so there was really nothing new or terribly unexpected about this piece.

Those in favour of the piece were equally strong in their opinions and their language as those against. The debate in many ways mirrored exactly the political situation and conflict under discussion—a seemingly irreconcilable conflict, at great cost to both parties.

Birte Twisselmann *technical editor*
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Competing interests: None declared.

1 MacIntyre D. Sharon wins historic vote to withdraw from Gaza. *Independent* 2004 Oct 27:1, cols 1-3.
2 McGreal C. Sharon wins historic Gaza vote. *Guardian* 2004 Oct 27:1, cols 1-3.
3 Electronic responses. Palestine: the assault on health and other war crimes. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7471/924 (accessed 27 Oct 2004.)

Medical education should include human rights component

Editor—Two important issues emerge from the article by Forrest and Barrett on humanitarian medicine.[1]

Firstly, the use of the terms "moderate physical pressure" or "torture lite" risks euphemising torture into acceptability. In 1976 the European Commission on Human Rights held that certain techniques used by the British security forces in Northern Ireland constituted torture.[2] These included forcing detainees to remain for some hours in a "stress position" and subjecting the detainee to continuous noise. The United Kingdom undertook not to use the techniques again. Doctors can see from this that the standards of international law regarding the prohibition of torture have been upheld even during a public emergency. The prohibition on states using torture is absolute, non-derogable, and unqualified.

Secondly, the international human right to the highest attainable standard of health is a measure which, by placing the patient's health as a doctor's prime concern, provides a legal justification to resist coercion to discriminate against individual patients, much less be complicit in torture.[3] The right to health is part of human rights law. Although states are ultimately accountable, health professionals have responsibilities regarding the realisation of the right to health.

Doctors should call governments to account for policies or practices that lead to torture, including those situations where medical staff are employed; but they need to do something further. They must demand that medical education include a human rights component. Unlike ethics, human rights codify universally accepted standards that are enforceable by law. Tomorrow's doctors deserve to be taught this.

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Competing interests: None declared.

1 Forrest D, Barrett J. Ethical pitfalls can be hard to avoid. *BMJ* 2004;329:399-400 (14 August.)
2 Ireland *v* UK (5310/71) Report: 25 January 1976.
3 United Nations. *General comment No 14*. New York: UN, 2000. www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument (accessed 17 Aug 2004).

Recent developments in Bell's palsy

Does a more recent single research paper trump a systematic review?

Editor—I am a jobbing general practitioner, and the paper by Holland and Weiner on Bell's palsy left me confused.[1] To treat somebody is a hard decision—not to treat somebody, even harder.

In 2002 the *BMJ* published an article about recent advances in neurology that proposed that there might be a case for prednisolone but none so far for antiviral agents.[2] This was based on systematic reviews.

This article quotes from just two more recent papers (Axelsson et al and Murakami et al[3 4]) and says that now the evidence base is clearly in favour of using antivirals. Given that further randomised controlled trials are in the pipeline, the authors' full support of antiviral use is more opinion than evidence, is it not?

Does a single more recent research paper trump a previous systematic review?

I was also concerned by the statement in the blue box at the start of the paper that claimed under recent developments that treatment of partial Bell's palsy is controversial: a few patients don't recover if left untreated. Is it not also true that a few patients don't recover even if treated?

In addition, I thought the article muddled and unhelpful. Should patients be admitted? What do the authors mean by psychological support?

Every year or so when I see a case of Bell's palsy I phone my local teaching hospital and ask the neurology registrar what the latest news is. The only thing I learnt from this article is perhaps I also ought to ask the registrar in ear, nose, and throat medicine too: perhaps we could have a live debate?

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Competing interests: None declared.

1 Holland NJ, Weiner GM. Recent developments in Bell's palsy. *BMJ* 2004;329:553-7. (4 September.)
2 Wiebe S, Nicolle MW. Recent developments in neurology. *BMJ* 2002;324:656-60.
3 Axelsson S, Lindberg S, Stjernquist-Desatnik A. Outcome of treatment with valacyclovir and prednisone in patients with Bell's palsy. *Ann Oto Rhinol Laryngol* 2003;112:197.
4 Murakami S, Hato N, Horiuchi J, Honda N, Gyo K, Yanagihara N. Treatment of Ramsay Hunt syndrome with acyclovir-prednisone: significance of early diagnosis and treatment. *Ann Neurol* 1997;41: 353-7.

Who should provide the care?

Editor—In the United Kingdom, Bell's palsy is mostly managed in primary care.[1] In Holland and Weiner's thorough and helpful account of its management the authors recommend that patients should be referred to a specialist as soon as possible.[2] It would be interesting to know more about their thinking: this would represent a change in practice for many general practitioners who routinely provide comprehensive and evidence based assessment and care for patients with new onset Bell's palsy, referring to specialists when specialist input is needed.

Holland and Weiner are apparently both otolaryngologists, so well qualified to advise on the management of Bell's palsy. I wonder whether their review would have been much altered had a general practitioner been included in its authorship.

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Competing interests: None declared.

1 Rowlands S, Hooper R, Hughes R, Burney P. The epidemiology and treatment of Bell's palsy in the UK. *Eur J Neurol* 2002;9:63-7.
2 Holland NJ, Weiner GM. Recent developments in Bell's palsy. *BMJ* 2004;329:553-7. (4 September.)

Trial for Bell's palsy is in progress in Scotland

Editor—Holland and Weiner's clinical review (albeit a traditional non-systematic, opinion based one) on the important topic of Bell's palsy is welcome,[1] but we are concerned that their conclusions about treatment are simply not supported by current evidence.

The most recent Cochrane reviews show that no treatment has yet been shown to be more effective than placebo.[2 3] The recent studies cited have not yet been included in the systematic reviews but since they are non-randomised, statements that combination therapy is beneficial are not secure.[4] Since these treatments are neither inexpensive nor harmless, the issue is important for clinicians, patients, and the health service.

The review by the American Academy of Neurology cited by Holland and Weiner concluded that well designed studies of the effectiveness of treatments for Bell's palsy are still needed. Published trials are mainly hospital based and involve small numbers.[5] We are running a trial that avoids these pitfalls and will hopefully provide an answer.

The Bell's trial (ISRCTN 71548196) is a randomised multicentre factorial trial of the early administration of steroids or antivirals for Bell's palsy. To our knowledge, it is the largest trial ever planned for Bell's palsy. We will randomise 720 patients over the next 18 months (www.dundee.ac.uk/bells).

We have been able to mount this trial because of the greatly improved research infrastructure in UK general practice in recent years. The Scottish School of Primary Care (www.show.scot.nhs.uk/sspc/) has developed a register of Scottish practices and professionals interested in research, which is working with others such as NHS24 to identify and refer patients early. Provided that Scottish general practitioners and accident and emergency doctors ignore Holland and Weiner's recommendations on treatment, we believe this trial will provide the evidence for treatment of Bell's palsy that is currently lacking.

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Competing interests: The authors are engaged in a randomised controlled trial in Bell's palsy that may be adversely affected by uncritical acceptance of Holland and Weiner's publication.

1 Holland NJ, Weiner GM. Recent developments in Bell's palsy. *BMJ* 2004;329:553-7. (4 September.)
2 Salinas RA, Alvarez G, Alvarez MI, Ferreira J. Corticosteroids for Bell's palsy (idiopathic facial paralysis). *Cochrane Library*, Issue 3. Chichester: John Wiley, 2004.
3 Sipe J, Dunn L. Acyclovir for Bell's palsy (idiopathic facial paralysis). *Cochrane Library*, Issue 3. Chichester: John Wiley, 2004.
4 Hato N, Matsumoto S, Kisaki H, Takahashi H, Wakisaka H, Honda N, et al. Efficacy of early treatment of Bell's palsy with oral acyclovir and prednisolone. *Otol Neurotol* 2003;24:948-51.
5 Rowlands S, Hooper R, Hughes R, Burney P. The epidemiology and treatment of Bell's palsy in the UK. *Eur J Neurol* 2002;91:6.

Authors' response

Editor—Most patients with Bell's palsy clearly do well with or without treatment. Outside certain patient subgroups, identifying who will fare well and who won't remains impossible. Therefore if treatment is to be given, all who are eligible for treatment must be treated for the benefit of the few. Although systematic reviews do not show statistically significant benefits, they are at least suggestive of benefit. The differences are small but for a disorder with much disability and cosmetic blight associated with it, the difference between treatment and non-treatment may be clinically very significant.

Our remit was to provide a summary of the current evidence, define from it, with a degree of pragmatism, what advice to give, and to inform discussions with patients. The uncertainties in the current evidence base, and possible solutions to it are clearly discussed in the paper. We allowed for these uncertainties, providing "support" (level B or C advice) rather than "recommendations" (level A advice), all that is possible given the current level of evidence. Our advice is compatible with the current evidence given the uncertainties within it. We are also certain that further studies are indicated because of those uncertainties, including placebo controlled studies such as the Scottish one.

We accept that there is no evidence that referral will lead to better outcomes but suggest that any patient is best cared for by a practitioner with an interest, who may treat, investigate, or refer onward for further management as appropriate. The fact that a sizable proportion of patients have an alternative diagnosis justifies this approach. As the facial nerve is a cornerstone in otological practice we feel well placed to manage facial palsy, and are pleased to see that this is the starting point for the Scottish study.

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Summary of responses

Editor—Holland and Weiner's clinical review on recent developments in Bell's palsy prompted 24 responses, 10 of them critical of the views on treatment.[1] The authors were wrong to recommend early treatment with steroids or antiviral agents, or both, because the supporting evidence they offered was inconclusive and flawed; they ignored the best evidence (two systematic reviews) and selected other trials to support their own opinion; neither treatment is harmless, and antiviral agents are expensive; and they glossed other potentially useful treatments.

A physiotherapist thought the review a bit light on facial retraining for people with residual paralysis, and a surgeon from Seattle wanted more on the potential benefits of decompression surgery. A patient said that speech therapy had been the only useful treatment, while other responses emphasised that most patients get better without any treatment at all.

Criticism of Holland and Weiners' use and misuse of evidence led to more general criticism of the *BMJ* for allowing them the space to do it in public. The *BMJ*, they felt, should be more rigorous and "evidence based." Just to emphasise the point, one response reports an obvious inconsistency between *Clinical Evidence*—the BMJ Publishing Group's most systematic and evidence based publication—which says that steroids are an unproved treatment for Bell's palsy, and Holland and Weiners' article—a mostly unsystematic review also published by the BMJ Publishing Group—which says that steroids might work and you should prescribe them as soon as possible to most patients.

So which wing of the *BMJ* should readers believe? A large new clinical trial is under way that will hopefully provide the answers.

Holland and Weiner recommend early referral to a specialist as well as early treatment with steroids. Three general practitioners from the United Kingdom disagree. "Prompt treatment, support, and follow up can all be effectively delivered in general practice with the option to refer patients who fail to improve or have poor prognostic indicators," says the first. "In an NHS where resources are so scarce, advice to refer patients who will not benefit from outpatient attendance is wasteful of resources."

Nine responses touch on the causes of facial palsy. A paediatrician writes that high blood pressure could be responsible for up to 17% of cases in children. There may also be a link between Bell's palsy and high blood pressure in pregnant women, says another respondent, citing a study showing that about a fifth of pregnant women who present with Bell's palsy develop pre-eclampsia. A third respondent describes the case of a young man who had three episodes of Bell's palsy before someone thought to look for, and found, coeliac disease. A gluten free diet has so far prevented any further neurological problems.

Infectious aetiologies seem more controversial. Lyme disease may be an established cause of facial palsy, but who should you test for Lyme disease and how? One respondent says the serological testing advocated by Holland and Weiner is unreliable. And a community paediatrician from Sweden suggests lumbar puncture to look for pleocytosis before risking treatment with corticosteroids.

Finally, two patients give insight on the impact of Bell's palsy on their social and working lives. "As chairman and MD of a software development company the facial deformity and the apparently drunken speech were not only embarrassing but made work virtually impossible by making sensible communication difficult," writes one. "The comparative rarity of the condition (20/100 000) in the UK and consequent public lack of awareness helped to reinforce the negative view of the facially distorted slurring stranger."

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Competing interests: None declared.

1 Electronic responses. Recent developments in Bell's palsy. Bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7465/553 (accessed 14 Oct 2004).