Gaza strip. At times, more than 100 rockets were being fired each month,[3] harming and killing many civilians, among them women and children. Despite these attacks, the Israeli government decided in 2005 to withdraw from the Gaza strip, as an act of good faith, and the last Israeli soldier left on Sept 11, 2005.[4]

For the Palestinian Authority, this was a remarkable opportunity to develop its civil services, infrastructure, and health system, and to create work opportunities using money donated by the international community. Instead, huge efforts and sums were directed to the development and launching of rockets deep into Israel, and the kidnapping of Israeli soldier Gilad Shalit from Israeli territory. He is still being held hostage in Gaza to this day.

After 8 years of restraint despite repeated and unprovoked attacks on its civilians, Israel had no option but to react forcefully. The operation was designed to minimise harm to the civilian population, although this was hampered by the fact that Hamas militants took cover in hospitals, school, and buildings occupied by civilians. During the operation, Israel transferred basic and medical supplies into the Gaza strip continuously, and an Israeli field hospital was established on the border for the Palestinians' use.[5]

We cannot imagine a more humane attitude by any country towards its aggressor, while suffering attacks against its civilians.

We declare that we have no conflicts of interest.

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1 Carter J. Peace and health in the occupied Palestinian territory. *Lancet* 2000; **373:** 783–84.
2 Giacaman R, Khatib R, Shabaneh L, et al. Health status and health services in the occupied Palestinian territory. *Lancet* 2009; **373:** 837–49.
3 B'Tselem. Attacks on Israeli civilians by Palestinians. http://www.btselem.org/english/israeli_civilians/qassam_missiles.asp (accessed March 9, 2009).
4 BBC news. 2005: last Israeli troops leave Gaza. http://news.bbc.co.uk/onthisday/hi/dates/stories/september/11/newsid_4954000/4954594.stm (accessed March 9, 2009).
5 Magen David Adom in Israel. Magen David Adom set up a clinic within 48 hours to treat the palestinian civilian population. http://www.mdais.com/316/4259.htm (accessed March 9, 2009).

I am a physician working in the Department of Emergency Medicine at a community hospital in Jerusalem, Israel. For almost 7 years I have been participating in the medical activities of Physicians for Human Rights—Israel (PHR-I) in the occupied Palestinian territory. Since Israel has placed many obstacles in the way of the Palestinian-run health-care system, I think that it is our professional commitment to support the right for health of the Palestinian people.

The March 7 issue of *The Lancet* marked the start of a Series on the health status of people living in the occupied Palestinian territory.[1] John Yudkin[2] correctly states that "Doctors and medical associations in the region could build bridges to create conditions to help alleviate suffering in the West Bank and Gaza". If this is the case, I wonder why the activity of PHR-I was not mentioned in this Series?

During 2008, PHR-I ran 61 mobile clinics in the West Bank and provided medical assistance to 9007 patients, of which 2065 were children. This represents an increase of more than 50% in the activity of the organisation compared with 2007. 271 physicians participated in these activities. This year, PHR-I assigned a budget of US$190 000 for these activities, which represents an increase of 30% from the previous year. During 2008, PHR-I provided escort to 1731 Palestinians from Gaza and the West Bank who asked for medical treatment outside of the occupied territories.

Delegations of Palestinian and Israeli physicians have been working together in Gaza in close coordination with the Palestinian Ministry of Health. These activities include providing medical advice to hospitals (eg, in oncology and orthopaedics), surgery in medical fields not available in Gaza (cardiac angiography, knee replacement), training of professionals in psychiatry, and professional meetings regarding medical needs and working plans.

I believe that PHR-I activity, which encourages cooperation in the health field based on the values of human rights, presents a positive alternative to the violence, and provides a bridge to achieving a genuine and just peace.

I declare that I have no conflicts of interest.

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1 Giacaman R, Khatib R, Shabaneh L, et al. Health status and health services in the occupied Palestinian territory. *Lancet* 2009; **373:** 837–49.
2 Yudkin JS. The responsibilities of the World Medical Association President. *Lancet* 2009; **373:** 1155–57.

Author's reply

I find it difficult to understand how Ted Tulchinsky and colleagues conclude that we "misrepresent trends in public health and health services" in the occupied Palestinian territory. As judged by infant mortality rates, which were noted graphically and in our texts and tables, Palestinian health conditions improved from 1967 until the early 1990s, continuing decades of improvements before 1967. Various factors are likely to have contributed to this trend:

(1) Improvements in material living conditions resulting from employment of Palestinians as cheap labourers in Israel especially during 1967–87, albeit at very high costs (individual incomes rose at the expense of institutional de-development[1]).

(2) The Israeli military immunisation programme for Palestinians, although this programme contrasted with the neglect of other health services provided by the occupying power—perhaps because infectious diseases do not know borders—and the dependence on Israel for medical services.

(3) Palestinian determination to resist occupation by developing their own health services independently of the Israeli military.

The fact remains that, as documented in Israeli military annual reports and other sources, health services for Palestinians during this period were starved of funds, lacked basic medications and equipment, and staff were inadequately trained and insufficient in numbers.[2] Indeed, the ex-deputy mayor of Jerusalem, Meron Benvenisti, found that the military government's entire civilian budget for Palestinians in 1980 was only 1·7% of the total civilian budget of the State of Israel, and 0·01% of the gross national product of the West Bank, and that there had been almost no government investment in infrastructure and development.[3]

The improving trends in health indices began to reverse in the 1990s, with stalling infant mortality rates and increasing stunting of children younger than 5 years. Our Series referred repeatedly to the multiple factors associated with these trends: Israeli military occupation of Palestinian land and its policies and practices; corruption and mismanagement of the Palestinian Authority; and a multiplicity of donors with different agendas and priorities.

Our Series provided minimal coverage of the attack on the Gaza Strip beginning Dec 27, 2008. We refer correspondents to other accounts relevant to that, such as that of the UN Human Rights Rapporteur in the occupied Palestinian territory, Richard Falk.[4,5]

Finally, we agree that Physicians for Human Rights—Israel is an outstanding organisation, which works with Palestinian partners on an equal footing. That is why we included many references to their reports and those of B'tselem, the Israeli human rights organisation. We wish to make clear that there are groups and individuals in Israel who are on the side of justice, including justice in health. These groups do not separate humanitarian, medical, or scientific work from solidarity with Palestinians and advocacy for justice and removal of the root cause of ill health: Israeli occupation of Palestinian land. It is time for Israelis, especially Israeli medical and health professionals, to face reality, acknowledge the root cause of ill health among both peoples, and work systematically for its removal.

I declare that I have no conflicts of interest.

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1 Roy S. De-development revisited: Palestinian economy and society since Oslo. *J Palestine Stud* 1999; **28:** 64–82.
2 Giacaman R. Health conditions and services in the West Bank and Gaza Strip. United Nations Conference on Trade and Development. UNCTAD/ECDC/SEU/3. Sept 28, 1994.
3 Benvenisti M. The 1986 report. Jerusalem: West Bank Data Base Project, 1986.
4 Falk R. Israel's war crimes. *The Nation* Dec 29, 2008. http://www.thenation.com/doc/20090112/falk?rel=hp_currently (accessed April 17 2009).
5 Harel A. IDF in Gaza: killing civilians, vandalism, and lax rules of engagement. *Haaretz* March 19, 2009. http://www.haaretz.com/hasen/spages/1072040.html (accessed April 27, 2009).

Prasugrel STEMI subgroup analysis

In Gilles Montalescot and colleagues' report on the subgroup with ST-segment-elevation myocardial infarction (STEMI) from TRITON-TIMI 38 (Feb 28, p 723),[1] non-fatal myocardial infarction was not adequately defined. This outcome drove most of the reduction in the primary composite endpoint seen with prasugrel versus clopidogrel. Food and Drug Administration Advisory Committee documents[2] reveal that asymptomatic elevations in cardiac enzymes accounted for many events, and that in all patients presenting with acute coronary syndrome (ACS) most non-fatal myocardial infarctions were periprocedural (table). Furthermore, when only site-reported events were counted, the reduction in the primary outcome with prasugrel was no longer significant, neither for the STEMI subgroup nor the overall ACS cohort.

	Clopidogrel (n=529)	Prasugrel (n=432)
≤24 h	308 (58%)	266 (62%)
>24 h to 30 days	48 (9%)	34 (8%)
>30 days to 1 year	154 (29%)	119 (28%)
>1 year	16 (3%)	10 (2%)
Unknown	3 (1%)	3 (1%)

Table: **Non-fatal myocardial infarctions not associated with stent thrombosis in all patients with acute coronary syndrome, by time from percutaneous coronary intervention[2]**

Also, Montalescot and colleagues claim that the bleeding risk was similar with prasugrel and clopidogrel. However, the STEMI subgroup was underpowered to detect a meaningful difference in this safety outcome. Given the lack of heterogeneity between the STEMI patients and the rest of the ACS cohort with regard to both risk and benefit, the risk estimate calculated from the entire study population is more appropriate. In this larger group, both thrombolysis in myocardial infarction (TIMI) major haemorrhage (hazard ratio 1·32, 95% CI 1·03–1·68) and fatal haemorrhage (4·19, 1·58–11·1) unrelated to coronary-artery bypass grafting were significantly increased with prasugrel.[3]

Lastly, although the STEMI subgroup analysis was prespecified, TRITON-TIMI 38 was not prospectively designed to assess the superiority of prasugrel over clopidogrel in this population.[4] Because α was not adjusted to account for the multiple planned and post-hoc comparisons that were made, it is likely that some of the positive findings are type 1 errors.[1] Thus, any conclusions drawn from these data must be regarded as exploratory at best.

We declare that we have no conflicts of interest.

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