

The study by Gilbert Burnham and colleagues¹ on the number of “excess” deaths in Iraq since the US invasion confirms what I saw with my own eyes during my time there in 2004, around the first anniversary of the invasion. Meeting with doctors and hospital officials, seeing the horrific conditions in hospitals, talking to Iraqis who, almost to a person, had stories of loved ones, friends, or acquaintances killed, wounded, or detained by US forces, and just experiencing the randomness of violence—feeling as much at threat from US troops as from Iraqi insurgents—all of these experiences convinced me that the situation in Iraq was far graver than Americans wanted to believe.

Even then, as one doctor explained, the Coalition Provisional Authority had sent out written orders not to release death statistics to journalists. But Iraqis knew full well what the costs of the occupation were, and doctors and health-care workers asked me to help bring in experts with computers to whom they could show their officially secret death records and who could compile an accurate account of the scale of death in the country. I was unable to convince anyone of the importance of this endeavour when I returned home.

This study, along with the 2004 study² that first alerted the world to the seriousness of the violence in Iraq, has filled that much needed gap. We would do well to stop trying to politicise its conclusion and begin the task of figuring out how to bring down the violence levels before another half a million Iraqis die.

I declare that I have no conflict of interest.

Mark LeVine
mlevine@uci.edu

Department of History, UC Irvine, 453 Krieger Hall,
Irvine, CA 92697, USA

- 1 Burnham G, Lafta R, Ducey S, Roberts L. Mortality after the 2003 invasion of Iraq: a cross-sectional cluster sample survey. *Lancet* 2006; **368**: 1421–28.
- 2 Roberts L, Lafta R, Garfield R, Khudhain J, Burnham G. Mortality before and after the 2003 invasion of Iraq: cluster sample survey. *Lancet* 2004; **364**: 1857–64.

Health in foreign policy

In correctly identifying health as the most important foreign policy issue of our time (Oct 21, p 1395),¹ Richard Horton has not prescribed the remedy—respect for international law. The invasion of Iraq certainly violated the spirit of international law by defying the expressed views of the Security Council, and many impartial observers including the UN Secretary General insist the invasion was illegal.² Additionally, the failure to implement a secure occupation so abject that it has resulted in civil war amounts to a war crime. Now the impunity those responsible expect to enjoy leaves the world in greater peril by encouraging copycat pre-emptive strikes—Pakistan and India come to mind.

General Comment 14 (paragraph 39) of the International Covenant on Economic, Social and Cultural Rights³ specifically requires states to respect, and discourage other states or international organisations from violating, health rights in other countries. Although General Comments are soft law² owing to their advisory status, they form the nearest thing at the UN to case law used in court-based jurisprudence.

Democratic governments are no less culpable when violating international law than totalitarian regimes, but the responsibility can be more devolved. The bottom line is that there can be no democracy without responsibility. Electorates must ensure the governments they elect respect international law and punish perpetrators.

I had a role in the development of General Comment 14 of the International Covenant of Economic, Social and Cultural Rights.

Peter Hall
peterhall@doctorsforhumanrights.org

Doctors for Human Rights, 91 Harlech Road, Abbots
Langley WD5 0BE, UK

- 1 Horton R. Iraq: time to signal a new era for health in foreign policy. *Lancet* 2006; **368**: 1395–97.

- 2 MacGaskill E, Borger J. Iraq war was illegal and breached UN charter, says Annan. *The Guardian* Sept 16, 2004: <http://www.guardian.co.uk/Iraq/Story/0,2763,1305709,00.html> (accessed Oct 15, 2006).
- 3 United Nations. The right to the highest attainable standard of health. Geneva: UN, 2000. [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument) (accessed Oct 15, 2006).

Prevention of vascular events in atrial fibrillation

In the ACTIVE W trial in patients with atrial fibrillation (June 10, p 1903),¹ the rate of haemorrhagic stroke was significantly higher in the group on an oral anticoagulation agent than in the group on clopidogrel plus aspirin (0.36% vs 0.12% per year). The number needed to harm was 417 per year. In other words, treating 1000 patients per year prevents 10 strokes and causes two haemorrhagic strokes. The risk of haemorrhagic stroke will clearly increase as patients get older,² which suggests that the risk could have been even higher if the trial, which recruited old people, had been longer. A long-term trial is therefore needed to test whether the risk of haemorrhagic stroke due to oral anticoagulation continues to increase among elderly patients with atrial fibrillation.

Another study has shown that patients with atrial fibrillation who are at high risk of falls are also at substantially increased risk of intracranial haemorrhage.³ Unfortunately, elderly patients at high risk of falls were excluded from clinical trials of stroke prevention in atrial fibrillation.³ It would be very important to know whether the participants in the ACTIVE W trial were at high risk of falling. In the real world, the benefit of reducing a few ischaemic strokes among the participants at high risk of falling could be counteracted by haemorrhagic stroke.

I declare that I have no conflict of interest.

Huai yong Cheng

The printed journal includes an image merely for illustration