did it?" and "How do we stop it?" may be of little relevance after an earthquake, they are uppermost in the mind of anyone subject to continual bombardment and ethnic cleansing. Failure to engage with these issues can increase a sense of victimhood and disempowerment; and attempts to remain politically neutral in the face of genocide may well be construed as tacit collaboration with the aggressor and make effective therapeutic work impossible.

Human identity rests on the network of social relations that we build around ourselves: the tie of family, work, and community, and the emotional bond we make with our physical environment. One might argue that the main psychic injury of war is the disruption of those ties, the destruction of identity through the destruction of our social world. Thus any thorough evaluation of psychological treatments for traumatic stress should compare their effectiveness with the impact on mental health of non-psychological interventions such as community redevelopment projects. Only then can scarce resources be allocated in the most appropriate way.

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1 Raphael B, Meldrum L, McFarlane A. Does debriefing after psychological trauma work? *BMJ* 1995;310:1479-80. (10 June.)
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Response to treatment varies

EDITOR,—Beverley Raphael and colleagues' editorial raises many questions about psychological debriefing and post-traumatic stress reactions.[1] A military debriefing is an analysis of the events occurring on a mission and the lessons learnt. The primary aim of psychological debriefing is to provide the person with as much information as possible from all the sources available to enable the cognitive appraisal and emotional processing of a traumatic experience. This may be therapeutic or may not be. Traumatic incidents irrevocably change people as they challenge fundamental beliefs and values—spiritual, philosophical, moral, and existential. In any experience many post-traumatic stress reactions are chimeric, and even the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, reflects the importance of the meaning of an event for the person.[2]

Any post-traumatic stress reaction is the product of three almost infinitely variable factors: the person's personality, coping mechanisms, and life experiences or abuses; aspects and meaning of the traumatic event itself; and the psychosocial environment into which the person returns. My, and others',[3] experience is that people with no, or few, scars from the vicissitudes of life and with good psychosocial support can survive almost anything. This model also explains how psychological debriefing may be followed by idiosyncratic responses or an apparent worsening in the person's condition; explains why no one intervention will "work" either before or after the development of a post-traumatic stress reaction; and suggests why it will be difficult to find controls for any randomised trial.

After traumas there is a natural need and desire to help, especially as social, cultural, spiritual, and humanistic dimensions exist alongside the medical and psychological ones. But there are darker aspects to providing help to the victims of traumas. These lie in voyeurism—vicariously listening to or experiencing salacious, sadistic, violent, even pornographic details of another person's life. It can prove an abusive experience for all parties. For this reason, those who provide psychological debriefing or treatment for post-traumatic stress reactions must have good psychotherapeutic skills and supervision.

Whatever the outcome of trials, I suspect that psychological debriefing is here to stay. Perhaps it has always been with us: "But we two snugly indoors here may drink and eat and revel in an interchange of sorrows—sorrows that are memories, I mean; for when a man has endured deeply and strayed far from home he can cull solace from the rehearsal of old griefs. And so I will meet your questioning."[5]

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Voluntary euthanasia commands majority support

EDITOR,—I fail to see how Anne Rodway can assert that voluntary euthanasia in Britain enjoys only minority support among the general public[1] when results of scientifically conducted polls emphatically tell a different story. A poll commissioned by the Voluntary Euthanasia Society in April 1993—the latest in a series each showing an increase on the last—showed 79% in support of euthanasia,[2] and countless other surveys, albeit less scientific, after newspaper and magazine articles and television and radio programmes show similar results. If Rodway still doubts the veracity of these surveys, I would draw her attention to a poll in 1987 commissioned by an antieuthanasia group, the World Federation of Doctors Who Respect Human Life, which found 72% in favour of euthanasia.[3]

Finally, proponents of voluntary euthanasia do not see it as "a substitute for caring and supporting"; they see it as a widening of choice for dying patients and a final act of care.

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Their lordships on medical research

EDITOR,—I am surprised that Richard Smith finds the report of the select committee on science and technology, based on the work of the subcommittee that I chaired, "too backward looking."[1] In the report the committee commends the government's initiative on research and development, the work of Professor Michael Peckham and his regional directors, the increasing development of health services research, and new trends in knowledge based and evidence based medical practice. The committee also recommends explicitly that when the recommendations of the Culyer taskforce are implemented a separate stream of funds should be identified at regional level to support research in general practice and community care as well as research by nurses and members of the other health care professions.

It is true that the committee is concerned about the infrastructure funding in the NHS for biomedical research and research driven by curiosity. The committee does not, however, reject the principle of a research assessment exercise within the NHS as in the universities; it suggests that, to avoid massive duplication of effort, the two processes should be combined and that a core of facilities funding should be preserved to maintain the ability of hospitals and other university based research departments (including academic departments of general practice) to continue with that biomedical and predominantly clinical research on which the future wellbeing of the nation depends. This is in no sense promoting an "ivory tower" approach, but it is a truism that today's discovery in basic medical science brings tomorrow's practical development in patient care. The report also quotes conclusive evidence to indicate that the major specialist research centres, some of which are indeed being starved of tertiary referrals, not only find that their research brings new knowledge about the management of disease but also improves clinical outcomes.

I am glad that Smith commends the committee's wish to see an urgent inquiry into the present and future of clinical academic medicine. He is right in saying that career problems in this field are not new, but the many new factors referred to in the report have greatly increased the sense of crisis that now abounds in the clinical academic community, and I trust that in this regard, as well as in many others, the committee's warnings will be heeded.

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1 Smith R. Their lordships on medical research. *BMJ* 1995;310:1552. (17 June.)

Effects of homoeopathy

Trial did not evaluate "true" homoeopathy

EDITOR,—Per Lökken and colleagues have made a laudable attempt to evaluate homoeopathy scientifically.[1] For orthodox methodologists the design of their study will seem rigorous, and therefore most conventional physicians and dentists will conclude that homoeopathy is not effective for the given indication. Homoeopaths, on the other hand, might have doubts about this conclusion, arguing that the protocol did not allow for the necessary freedom of homoeopathic prescription: the doses were fixed (at D30), and so was the treatment schedule (four doses during the first three hours, etc), yet homoeopathy requires these to be flexible and fully individualised. Thus homoeopaths might think that the results would have been different if true homoeopathy had been practised.

It might also be argued that arnica, which was the most commonly used remedy in this study, is ineffective but homoeopathy may still work. Others might think that it was a bad idea for some of the subjects to be students of natural medicine, who might respond typically. Finally, one might speculate that the prescribing homoeopaths (who and how many were they? Did they reach individual or consensus decisions about which drug to use?) were ineffectively using a potentially effective form of treatment.

These arguments highlight the immense difficulties that are encountered when evaluating homoeopathy scientifically. Given that there are hundreds of remedies to be applied in hundreds of