basic life support with early defibrillation.[1] A retrospective study in Hampshire of 98 patients who had a cardiac arrest outside hospital showed that the introduction of paramedics resulted in an increase in the number who regained spontaneous cardiac output from 12 to 21 (P=0·01).[2] The number who survived to discharge from hospital, however, did not increase.

In the group treated by paramedics seven of 23 patients who regained spontaneous cardiac output were in asystolic arrest or electromechanical dissociation when first monitored. In the group treated by ambulance technicians only one patient who regained spontaneous cardiac output had such an arrest. The success of initial resuscitation showed a direct but transient benefit of intervention by a paramedic since none of these patients survived to discharge. In both groups three of 23 patients with ventricular fibrillation survived to discharge.

These findings reflect the irreversible pathophysiology and grave prognosis of cardiac arrest when the initial rhythm is not ventricular fibrillation. This is irrespective of where the arrest occurs. Furthermore, the principal therapeutic goal in ventricular fibrillation remains prompt defibrillation.

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Studying only admissions is a source of potential bias

EDITOR,—U M Guly and colleagues state that their study, which claims to show that "paramedics and technicians are equally successful at managing cardiac arrest outside hospital," does not "diminish the role of paramedics."[1] Yet the paragraph about their paper in This week in *BMJ* concludes that such patients "are best treated" by technicians and calls into question the requirement of having a paramedic in every emergency ambulance. We do not believe that such a conclusion can be safely drawn from the data presented.

The methodology gives rise to several sources of bias. Information is presented for those patients taken to the emergency department and not for all patients sustaining cardiac arrests in the community. In our series, based on telephone interviews with ambulance staff, 30% of all patients were certified dead at the scene, and for every three cases in which resuscitation was attempted there were two cases in which it was not; paramedics were more likely to start resuscitation.[2] Moreover, if ambulance controllers base their decision to dispatch technicians or paramedics on clinical information, random allocation of crew is unlikely. Thus the two types of crew may not resuscitate patients with the same likelihood of success before the intervention.

Furthermore, a comparison of times spent at the scene and outcome may be distorted by the inclusion of patients attended first by technicians and then by paramedics in the group treated by paramedics. Our data (table) show that these patients spend the longest times at the scene of the arrest. In our community based study of arrests due to all causes, paramedics, who (unlike those in Guly and colleagues' study) were able to give drugs, compared favourably with other crews. Therefore, while we agree that it is most important to provide rapid defibrillation, giving drugs (according to the European Resuscitation Council's guidelines) may be important.

Outcome of cardiorespiratory arrest outside hospital managed by South Glamorgan Ambulance Service (figures are numbers (percentages))

	Technicians with basic life support skills alone	Technicians with basic life support skills and defibrillators	Paramedics	Paramedics providing back up to technicians
Median time at scene (min)	10	13	22	30
Total No of attempts	252	102	517	83
Certified dead	75 (30)	34 (33)	158 (31)	18 (22)
Admitted	31 (12)	10 (10)	86 (17)	9 (11)
Discharged	11 (4)	5 (5)	46 (9)	6 (7)

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Debriefing after psychological trauma

Inappropriate exporting of Western culture may cause additional harm

EDITOR,—Trauma is a growth industry in the West and thus fertile terrain for fashion. Beverley Raphael and colleagues note that debriefing after psychological trauma, which they call a social movement, is being widely instituted in advance of objective evidence of efficacy.[1] I wish to highlight one aspect with considerable implications: the export of Western psychological practices of this kind to various peoples affected by war worldwide.[2]

Rwanda is a good example. The first flows of destitute Tutsi refugees into Tanzania had scarcely abated when various aid organisations in the West were deciding from afar what was a priority—namely, "counselling." Projects were implemented without prior consultation with the refugees themselves or knowledge of their cultural norms and frameworks for psychological health, which are so different from those in the West. The experience of war is a collective one; processing it is a function of what it means or comes to mean. In the Rwandan case this will be coloured by what previous massacres have come to represent in Tutsi and Hutu social memory and the coping strategies used then. The notion that the complex and evolving impact of such events collapses down in a survivor to a discrete mental entity, the "trauma," that can be addressed by debriefing or similar approaches is risible. Projects should primarily target the impoverished social context of the survivors.

Psychosocial projects in war zones have become attractive for Western donors, driven in part by some expansive claims by professionals. For example, mental health advisers to the World Health Organisation and other agencies state that there are 700 000 people in Bosnia-Herzegovina and Croatia with severe trauma needing urgent treatment and that local professionals can handle less than 1% of these.[3] As a consultant to Oxfam I see these claims as misconceived, reflecting a narrowly pathologising view in which distress is relabelled as psychological disturbance. They also aggrandise the foreign experts who define the disorder and bring the cure. They risk distorting the wider debate about the destructive effects of war, including those on health. These trends can also pose dilemmas for indigenous organisations serving groups affected by war. Workers see that the central problem is the broken social world of these people, including poverty and lack of rights, but tell me that it seems easier to obtain funding from Western donors if they portray it as "trauma," whose antidote is "counselling."

Western psychological ideas are part of Western culture, which is becoming increasingly globalised. It would be ironic if trauma projects unwittingly generated the further disempowerment of non-Western communities weakened by war by presenting Western psychological thought as definitive knowledge and imputing inappropriate sick roles to the communities. The health and humanitarian fields are not exempt from issues of power and ideology.

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Response to stress is not necessarily pathological

EDITOR,—Beverley Raphael and colleagues' critical examination of the value of debriefing after psychological trauma focuses primarily on treatment after single disasters but could be extended to the wide range of psychological treatments offered to victims of current wars.[1] The failure of the concept of post-traumatic stress disorder to embrace the complexity of the experiences of suffering and loss in these situations has been addressed by other authors,[2] including me.[3] The treatment strategies that follow in its wake are equally problematic. They rest on an assumption of a pathological response to stress that is both universal across different cultures and centred on the individual. They ignore the continuing trauma of flight and resettlement that is experienced by refugees, and of life in regions of continuing conflict. And there is the possibility that they pathologise coping strategies that might be essential to survival. Hypervigilance—the ability to distinguish the sound of an incoming from that of an outgoing mortar, for example—may mean the difference between life and death in Sarajevo. Numbing and denial may allow a person to muster the psychological strength necessary for flight and to endure the miseries of refugee camp life as well as make possible courageous acts of non-violent resistance.

The authors are right to point out that the provision of psychological first aid answers the need of mental health workers to make an immediate response to suffering. I would also suggest that, through its focus on intrapsychic processes, this approach allows the workers to avoid the complexities of political and social causation and maintain that detached objectivity that is the professional ideal. The problem is that while questions such as "Why did this happen?" "Who

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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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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2 National Opinion Poll. *Euthanasia.* London: NOP, 1993.
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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