an atmosphere that is still chilly towards primary care. There has been further growth in specialisation, with differences in income and status between specialists and generalists.[3] There is a funding bias towards basic research and against clinical research.[1] Furthermore, specialised and general medical journals are sometimes reluctant to publish general practice research.

From the point of view of general practice, the extent to which research can influence clinical practice and the effect academic medicine might have on patients' wellbeing—intuitively relevant aspects—are not always taken into account. This stresses the future role of academic medicine and academic medical journals.[5]

I declare that I have no conflict of interest.

Jan Matthys
matthys.jan@pandora.be

Department of General Practice and Primary Health Care, Ghent University, 1K3, De Pintelaan 185, 9000 Gent, Belgium

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In his Viewpoint,[1] Desmond Sheridan states that the bureaucracy of drug regulation and market access across Europe is more varied and complex than in the USA, making Europe less attractive for research investment. This is not only true for industry, but even more so for academic clinical research.

The European Clinical Trials Directive,[2] which was driven by the European Commission Enterprise Directorate General to harmonise and simplify European clinical research, has been more a hindrance than a help to academic research by ignoring the academic environment and by allowing member states too great a margin for interpretation. The conduct of many research projects, monocentric as well as multicentric, is not possible any more. A further directive[3] will possibly allow implementation of specific regulations for non-commercial trials. But substantial damage has already been done.

Several initiatives to "revitalise" European academic research have been established over the past 2 years, among those the Vienna Initiative to Save European Academic Research (VISEAR),[4] which concentrates on issues such as the definition of sponsorship in clinical trials, the heterogeneous ethical review system in Europe, and research in emergency medicine.

European research is still dependent on US databases and scientific assessment: as long as the European Clinical Trials Database (EudraCT) is not publicly accessible and European scientific output is measured by a non-public US enterprise (Institute for Scientific Information), European autonomy and scientific excellence will hardly develop. European research needs to be more independent and self-confident to reverse its decline.

We declare that we have no conflict of interest.

**Christiane Druml, Ernst A Singer, Michael Wolzt*
christiane.druml@meduniwien.ac.at

Ethics Committee of the Medical University of Vienna and the Vienna General Hospital, Borschkegasse 8b, 1090 Vienna, Austria

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Disaster-related mental health: indoctrination or collaboration?

Margaret Harris Cheng's review of conditions in Sri Lanka (Jan 7, p 15)[1] after the tsunami of Dec 26, 2004, outlines the work of non-governmental organisations in restoring and improving housing, food distribution, livelihood, and—the main focus of her article—mental health services. Although improving mental health services anywhere is laudable, the assumption that they come into existence in developing countries only when Western-style practitioners arrive is arrogant and wrong. Sri Lankans, for example, have been treating trauma for millennia. Those who visited the island after the tsunami had—and have—as much to learn from Sri Lankans about mental health as do Sri Lankans from them.

An important lesson to be learned from overseas relief work is that dialogues among practitioners of different backgrounds benefit all. Learning is mutual. Ironically, Western practitioners who travel abroad without the respect and openness that dialogues demand undermine the very foundation on which their mental health practices are based.

In the West, one "goes" to a "counsellor" for "treatment." In developing countries, however, treatment is found not in a consulting room, but in the community itself. Visiting practitioners can be most effective by assisting local practitioners to identify healing practices that are implicit in the community.

Harris Cheng's article ends with an account of the Hong Kong Red Cross's

model for housing, which "will not be lived in until the community for which it is being built has approved it". Western mental health practitioners would do well to follow that example by assisting disaster-affected communities through collaboration, rather than through indoctrination.

We declare that we have no conflict of interest.

*John R Van Eenwyk,
Janaka Jayawickrama
jrv@u.washington.edu

The International Trauma Treatment Program, 1026 State Avenue, Olympia, WA 98506, USA (JRVE); and Trauma Risk Reduction Programme, Disaster and Development Centre, Northumbria University, School of Applied Science, Newcastle upon Tyne, UK (JJ)

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Making the UK's National Health Service cost effective

The Comment by Niall Dixon and Jennifer Dixon (June 3, p 1302)[1] supports the notion in the UK government's current white paper that success is dependent on changing the balance of health-care provision from a hospital-centred to a community system. However, health-service provision in the UK is structured along horizontal lines in which primary care competes with secondary care in an attempt to reduce costs, and a third party—the general practitioner—negotiates on behalf of the patient.

The drivers for change in modern health care require a vertically integrated system in which patients' needs throughout the complexity of health and social care are seen as a seamless, singular, trajectory. The government should focus its energy in creating a vertically integrated health-care system, which is responsive to the needs of patients, in which competition between different medical systems drives value into the practitioner–patient interface.

I am Director of Metris Therapeutics, Gene Networks International, and Ziva Bioscience.

Stephen K Smith
s.k.smith@imperial.ac.uk

Faculty of Medicine, Imperial College, London SW7 2AZ, UK

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Tobacco industry research on smoking and cigarette toxicity

Michael Dixon and Stewart Massey (April 22, p 1317)[1] criticise our review of internal research by British American Tobacco (BAT) and Imperial Tobacco Limited (ITL) on smoking behaviour and product design.[2] They dispute the notion that BAT and ITL have exploited the international testing standards for cigarette emission.

Our paper describes internal documents which suggest that BAT designed products to maximise the discrepancy between: (a) the tar and nicotine numbers under standardised testing and (b) the levels that could be delivered to consumers. Moreover, the documents we reviewed indicate that this strategy was kept secret from consumers and regulators. Dixon and Massey seem to suggest that this was "fair game" because regulators acknowledged certain limitations of the testing regimen when it was introduced. Their argument would be more compelling had their companies not also marketed these brands as low-tar alternatives for health-concerned smokers and had they not attached misleading descriptors such as "light" and "mild" to brands that generated low machine readings.[3] Indeed, BAT product scientists worked closely with the marketing department to develop such synergies.

Dixon and Massey also suggest that the industry has previously disclosed much of the research we describe in our paper. Even if all of the information in our review had been previously disclosed, it still warrants alarm among consumers and regulators. However, to suggest that the industry has been forthright about their product research and strategy is simply not credible. Tobacco manufacturers have a track record of publishing only those research findings that either obscure or undermine scientific questions with public-health implications.[4] Additionally, our paper cites a memo from Alan Heard, a senior BAT scientist, to S R Massey. Heard writes: "Instinctively I question the idea of publishing papers in relation to smoking behaviour...I think it is unwise to publish any findings of our studies on smoking behaviour on any smoking products."[5]

Dixon and Massey also reject the suggestion that BAT and ITL have designed "elastic" cigarettes. The term "elastic" is not our invention; rather, it is drawn from the BAT documents we reviewed. Our paper may or may not include the best examples of product elasticity; however, statements made by senior BAT employees leave no question as to the reality of "elastic" cigarette designs.

I declare that I have no conflict of interest.

David Hammond
dhammond@uwaterloo.ca

Department of Health Studies and Gerontology, University of Waterloo, Waterloo, Ontario N2L 3G1, Canada

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