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