benefit individual patients.²⁻⁴ They need to be large enough to allow sufficient statistical power to answer the research questions posed. It is also known that only a small proportion of eligible patients are entered into such trials (for example, only 3-5% of patients with cancer in Britain are included in clinical trials⁵). Among the many reasons for this lack of accrual is a belief that multicentre trials do not officially recognise the considerable time and effort required by clinicians to identify suitable patients, obtain informed consent, and complete the necessary forms.

Incentives to recruit patients into trials are required. We suggest that clinicians' vital contribution to randomised controlled trials should be acknowledged separately at the end of published papers. In large multicentre trials it is often not practical or desirable for all collaborating clinicians to be mentioned as authors of papers. Thus many people's efforts in recruiting patients to trials go unrewarded: they do not have publications to their name, and their research is denied the recognition that, since the publication of the Culyer report,⁵ is now necessary to gain funding. Benefits could be gained if it became standard practice for all published papers to incorporate a list of clinicians who enrolled more than a (trial specific) number of patients into the trial. Not only would this acknowledge the important work of these clinicians in the trial but it would also provide evidence of their participation in research for academic assessment and for their curriculum vitae and provide kudos for the clinicians and their department.

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Childhood bereavement

Bereavement is painful but does not necessarily make children ill

EDITOR,—Dora Black suggests that bereaved children and their families should routinely be offered counselling to prevent depression and other mental health problems in the future.¹ Although psychiatric morbidity is increased in bereaved children, however, most of them do not develop important depressive conditions.² Indeed, the association with child psychiatric disorder is not as strong as when the child has lost a parent through divorce or separation.³ Bereavement is painful but does not necessarily make children ill. Most bereaved children rely on family and personal resources to deal with their loss and do not require professional help.

There can be substantial problems in setting up successful primary preventive programmes for bereaved children,⁴ not the least of which is the problem of funding. It is difficult to justify diverting scarce resources from the treatment of children with established mental disorders to provide counselling for children at risk. Such a strategy would have to be supported by

compelling evidence from randomised trials that counselling of bereaved children is an effective way of preventing mental illness, but no such evidence exists.¹

Furthermore, counselling after bereavement, however well intentioned, may be harmful to some children. We know surprisingly little about the process of bereavement among young people. It cannot be assumed that concepts borrowed from research with bereaved adults, such as the idea that bereavement consists of a series of "psychological tasks" that must be completed, apply to children. Yet such concepts are often advocated by those working in the field⁵ and form the basis of treatments such as forced mourning. Until we know more about the efficacy of preventive interventions for bereaved children, psychological treatments should be reserved for those children and families who are clearly having problems.

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People with learning disabilities also need help in bereavement

EDITOR,—Dora Black advocates early intervention for bereaved children.¹ We should also provide intervention for people with learning disabilities. There is often a mistaken belief that such people need to be protected from the knowledge of death either because they do not understand the concepts or because they will cause difficulties for others.

Harper and Wadsworth have reported their preliminary findings that people with learning disabilities display grief responses similar to those of other adults and that the experience of grief does not depend on intelligence.² Responses to grief might, however, be prolonged, and a range of other behaviours might also be exhibited. I have found that many people with learning disabilities are not told when a parent dies and continue to be excluded from participation in rituals surrounding the death. They may also suffer the trauma of being removed from their home, sometimes immediately after the parent has died and often without a single object to remind them of the dead person.³

Great advances in knowledge are being made about the possibilities of psychotherapy for people with learning disabilities.⁴ There needs to be greater awareness that in this group the response to grief may present as altered behaviour. Primary prevention might include preparation by means of group work and sensitive planning by services. After a bereavement the person needs to be given unambiguous information and encouraged to participate in the rituals surrounding death. Carers and support workers should be given specific training, and appropriately adapted counselling—for example, based on non-verbal techniques such as art therapy—should be made available. Liaison with established agencies (whose staff may lack skills in dealing with this

group) would be helpful. Early detection and treatment of psychiatric disorder are essential. Further research is needed to evaluate the usefulness of other interventions—for example, an extended role for case managers. Above all, compassion and understanding are necessary for bereaved people with learning disabilities.

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Asylum seekers who claim to have been tortured should have right to independent medical examination

EDITOR,—I have recently helped to prepare a medical report on a young Nigerian who claims that he was tortured during detention in Nigeria. No charges were ever brought against him despite months of detention under appalling circumstances. His crime was apparently that of belonging to and working for the Campaign for Democracy. He was held in detention in Britain for a year (presumably at enormous expense to taxpayers) while his claim and appeal were considered. During that time he was interviewed by an immigration official who noted that his story was almost certainly false because he avoided eye contact throughout the interview. His appeal against deportation was rejected. Those who have worked in Africa will know that "looking away" is a sign of courtesy and respect in many cultures and is nothing to do with honesty. A medical examination requested by friends of the victim showed that the scars on his body supported his story. On the basis of this his case was reviewed and he is to be allowed to stay in Britain.

Claims of torture are notoriously difficult to check because, for obvious reasons, reports by witnesses are hard to come by and cannot be checked. An independent medical report, as used by the courts in cases in which claims are being made for personal injury, offers an opportunity to check the story told by the victim and should be used in disputed cases.

The Asylum and Immigration Act, which was recently rushed through parliament under dubious democratic procedures, was apparently designed to reduce the flood of applicants for asylum but seems to offer nothing to distinguish genuine applicants from economic migrants. Those applicants claiming to be victims of torture should have been given the right to a full independent medical report.

We have a duty to offer help to those people who have the courage to speak their minds in countries where this is a crime punished by torture and imprisonment without trial. Under the new regulations many political refugees whose applications are genuine will stand no chance of a fair hearing.

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