

fatiguability is consistent, which it would be if it were due to loss of tolerance or poor fitness. On the contrary, exercise tolerance varies initially and the temptation is to carry on, often with disastrous consequences, especially to morale. It is the variability that is so difficult to cope with in aligning the expectations of the sufferer and the observer.

I would conclude that the advice of Dr Wessely and colleagues may be correct in some cases and is certainly helpful. However, in the early case the primary concern is recognition, rest, emotional support and gradual steady rehabilitation.

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Sir,

While admiring the approach of Wessely and colleagues to the management of a difficult group of patients, I do not feel the authors can apply their rehabilitative strategies to those people who genuinely suffer from the chronic fatigue syndrome.

Contrary to their statement about normality of dynamic muscle function in such patients, it has been neatly demonstrated by nuclear magnetic resonance¹ that early and excessive intracellular acidosis occurs in affected muscles on exercise. It is postulated that this is due to an increase in energy production via glycolysis rather than oxidative pathways. Presumably this is the cause of the cardinal symptom of the chronic fatigue syndrome: exhaustion following moderate exercise.

Rather than suggesting that patients think 'I feel tired because I haven't been doing much lately', they should say 'I feel tired because my muscles are full of lactic acid'.

Since these biochemical abnormalities have been shown to persist for at least four years, I do not think graded exercise is going to cure them. Although the ME Association factsheet advising wheelchairs, mobility allowance and an invalid's parking permit seems nihilistic, it may be the most pragmatic approach until we can offer sufferers a decent therapeutic alternative.

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Reference

1. Arnold DL, Bone PJ, Radda GK, *et al.* Excessive intracellular acidosis of skeletal muscle on exercise in a patient with a post-viral exhaustion/fatigue syndrome. *Lancet* 1984; 1: 1367-1369.

Sir,

My general practitioner has drawn my attention to the paper by Wessely and colleagues. As someone who has been suffering from post-viral fatigue syndrome for the past year, I welcome the publication of anything which may help in the management of this wretchedly debilitating syndrome. However, I feel horrified by the authors' suggestion that doctors should encourage patients suffering from post-viral fatigue syndrome to undertake exercise even when patients are convinced that this makes their condition worse. It is of course probable that some people believing themselves to be suffering from post-viral fatigue syndrome may be unnecessarily and even detrimentally constraining their activities. But for many sufferers even very small amounts of activity are likely to worsen the symptoms and to lengthen the time it takes to reach recovery, particularly when the syndrome is in its early stages (which can last up to two years or more) and when the sufferer is in relapse.

As the authors acknowledge, little has so far been written about the treatment of the syndrome in the medical literature, but they appear lamentably unaware that a considerable amount has nonetheless been produced by a number of people with extensive experience of the syndrome and its management, such as the ME Association, Ho-Yen¹ and Wilkinson.² Everything I have read emphasizes that it has been found essential for sufferers to learn to recognize their limitations, and to exercise the self-discipline necessary to live within them.

This advice reflects my own experience. I benefitted from an early diagnosis and a sympathetic general practitioner, and felt able from the outset to accept that with the current state of medical knowledge the medical profession has little to offer other than diagnosis and symptomatic relief. I found that I had to take responsibility for the management of my illness (the approach that I subsequently found to be advocated by Ho-Yen), and I have now become reasonably expert in it. The symptoms fluctuate greatly and initially I failed to accept that I was ill and to make appropriate adjustments to my lifestyle — in which work and mountaineering were then the dominant passions. However, I then faced up to the fact that I was obliged to make getting better the first priority in my life. Now, a year later, I have made a lot of progress and have managed to return to full-time work — but only by rigidly avoiding excess exercise or other activity. What constitutes 'excess' varies enormously. I continue to be vulnerable to relapses, and at such times walking 50 yards is without question deleterious. At good times

however — for example, towards the end of a week's holiday — I can manage a six-mile walk (providing it is on easy terrain). I have learnt to judge what I can manage at any time. My judgement is not perfect and I still overdo it, and that makes me feel unwell for up to two weeks. Going beyond what I recognize to be sensible, in the rare circumstances when it is unavoidable, leads to a full relapse. None of the effects of over-activity are pleasant, so I tend to be cautious — sometimes, no doubt, over-cautious. But I am convinced that curtailment of activity has been a quintessential ingredient of my recovery to date, and that its continuation will be essential to my hopes of eventual recovery.

I have the good fortune to be well-educated, articulate and self-confident; to have suffered post-viral fatigue syndrome to only a relatively mild degree; to have been able to come to terms with my illness quite quickly; and to have a good relationship with my general practitioner as well as the support of my partner and family. What worries me greatly is that other sufferers in less favourable circumstances will be less able to make and to stick by their own decisions about their illness. Such people may be persuaded by their medical practitioner, against their own better judgement, to increase their activity levels and suffer what could be great damage.

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References

1. Ho-Yen. *Better recovery from viral illness*. Second edition. Inverness: Dodona Books, 1988.
2. Wilkinson S. *ME and you: a survivor's guide to post-viral fatigue syndrome*. Wellingborough: Thorsons, 1988.

Corrigendum — A sentence in Professor Field's letter about the chronic fatigue syndrome in the April issue (p.171) should have read 'Incidentally, about 40% of families ... show more than one case in the family' and not 80%.

Role of the community pharmacist

Sir,

The paper by Dr Roberts (December *Journal*, p.563) displays an almost complete misunderstanding of the role of the community pharmacist. It reveals a touching faith in the infallibility of computers, about health education of patients by doctors and about the takeover of various community duties by other members of the primary care team.

I should like to broaden the debate by discussing it in more sociological terms.

Since the inception of the National Health Service there has been an opinion that much minor illness which can be dealt with at home should be channelled into general practitioners' surgeries. As someone who attended Balint groups at the Tavistock Institute for four years I well understand that many patients present with minor illness as a necessary and sometimes covert introduction to a discussion of major importance. Nevertheless, I subscribe to the belief that some patients are genuinely at a loss as to how to deal with minor illness, an attitude engendered if not stimulated by the characteristics of the NHS, and by patients finding that the doctor's surgery is a convenient avenue for advice.

Dr Roberts' paper continues and perpetuates the sociological process which began in the twelfth century, and reached its height in the eighteenth century, at which time apothecaries saw approximately 20 patients for only one seen by the physician. Physicians accused apothecaries of being incompetent while apothecaries complained that physicians were arrogant, unfamiliar with the medicines that they prescribed and made unfair profits. The rivalry continues to this day with physicians gaining the ascendancy, obtaining (and retaining) the control of the 'social object',¹ that is, the drug, and I would suggest that this article reflects the rivalry between pharmacists and dispensing general practitioners.

But there is a different scenario possible in the NHS. We have a stratum of general practitioners, vocationally trained and with full access to investigations, at a time when hospital physicians have become more and more specialized. If

general practitioners could devolve many of their patients with minor illness to pharmacies, they could then act in place of the fast disappearing general physicians. Of course, pharmacy students would need better training in clinical pharmacy but this is currently taking place.

One possible result is that outpatients' departments would be able to function more effectively. With fewer patients, waiting lists could be drastically cut and consultants would be able to act in true consultant fashion. This would result in a shift of care from the secondary to the primary field and similarly in a shift of minor illness from doctors' surgeries to the pharmacies. Perhaps general practitioners could then turn their efforts to family care, prevention, health education, and into generally improving the quality of personal contact with patients. This may be cost-effective and as safe as the present system with good training. It would also be vocationally satisfying for consultants, general practitioners and pharmacists. Perhaps the time has come for some lateral thinking.

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Reference

- ¹ Denzil NR, Mettlin CJ. Incomplete professionalization: the case of pharmacy. *Social Forces* 1968; 46: 357.

Sir,
Dr Roberts, chairman of the Dispensing Doctors Association, has a narrow view

of the pharmacist's role in the health care team. We would like to present another view of the community pharmacist's current role, one which is closer to reality.

The Nuffield report on the present and future role of community pharmacists¹ accepted that the manipulative skills required to dispense a prescription have been reduced. However, the 'change in nature of drugs has increased the potential demand on a pharmacist's knowledge'. While acknowledging the increasing use made of computers, the report emphasizes the pharmacist's personal involvement in cases which call for the application of pharmaceutical knowledge. In this area, the committee were referring to a service to general practitioners which would enable them to make better prescribing decisions.

A second role was highlighted: to assist patients in the handling of their medicines. This embraces the many and varied aspects of health education. Patients remember just over half of the information provided in a consultation.^{2,3} Furthermore, there is evidence to suggest that some prescribers fail to instruct patients fully about their medication regimens.^{4,6} Pharmacists are in the unique position of being able to remind patients of important information and reinforce concepts and behaviour strategies suggested by the doctor.

About 25% of all prescriptions written by prescribers, and more than 50% written by ancillary staff, are not complete or have some error.⁷ Neither doctors nor pharmacists should be deceived into thinking that the computer will end such errors: the human hand still has to guide the computer — another reason for the



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