Sir,

Dr Aldridge states that the old order is being challenged. This may well be so, but the challenge is, I suspect, from a more ancient tradition.

The science of Newton and Descartes has certainly served us well, and the value of the discoveries of Koch and Pasteur cannot be denied. The reductionist view of disease is, however, reaching exhaustion. Focusing on finding a cause for a disease and a mechanism for a treatment has blinkered our vision.

McWhinney makes a clear distinction between the complexity and subjectivity of illness and the theoretical concept of disease.[1] Others have also offered broadly similar models of illness.[2] In the book *Medical choices: medical chances,* the authors develop the concept of the 'probabilistic' paradigm.[3] Simply put, there is no single cause and single effect; no one experiment can prove or disprove an hypothesis; subjectivity blurs with objectivity. They highlight Heisenberg's uncertainty principle which states that the object or process being observed can no longer be treated as an isolated system, the act of observation itself interferes with the purity of the experiment. At the heart of this paradigm is the realization that most of our daily practice involves coping with uncertainty.

I am, therefore, concerned that an attempt is made to explain what happens during the healing process. Trying to find out, interferes with the process and will lead us down the reductionist road, which will ultimately blinker us to what is really happening.

Perhaps the ingredients of healing are those expressed by Paul:[4] 'Meanwhile these three remain: faith, hope, and love; and the greatest of these is love'. Research should be directed towards understanding what we can do with the patient who consults us to maximize the opportunities for healing. I believe the healers of ancient times knew this, and I believe the best doctors now know this too.

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Sir,

I am a member of the doctor–healer network, which is a group of doctors and healers that meet to discuss ways of integrating healing into medical practice. There is much that we as doctors can learn from healers, in being more sensitive to patients, and preventing ourselves from being drained of energy during our work. Healers can also learn from us.

For the past four years I have had a spiritual healer sitting in on one of my normal morning surgeries on a weekly basis. Generally it is well accepted by patients. Besides the physical, emotional and the mental aspects of illness, we focus on the spiritual, even considering a diagnosis and treatment in spiritual terms.[1]

For the last eight months on one afternoon each week I have been running a healing clinic. Two healers give hands-on healing for 20 minutes for each patient. I sent out questionnaires in an attempt to measure any change in patients' conditions: almost every patient reported feeling more calm and relaxed. There have been no miracle cures but some surprising changes in attitudes for the better in patients, particularly those with chronic conditions. Certainly healing is much appreciated by those attending, and there are no side effects.

I feel that spiritual healing often improves a patient's health. Trying to measure these changes and prove them to colleagues is a difficult challenge, but in the meantime I would urge general practitioners to be open to the possibilities that healing can offer.

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Reference

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Chronic fatigue syndrome

Sir,

We welcome Goudsmit and colleagues' comments (letters, November *Journal,* p.479) on our paper (August *Journal,* p.339) and wish to reply to the points raised.

First, the definition as used in our paper is based on the salient features of the recent consensus criteria for chronic fatigue syndrome.[1,2] These are intended only as a guide for the clinician, and are not meant to be comprehensive. The term chronic fatigue syndrome was used as it is now widely used in the scientific literature.

We are not certain that the term myalgic encephalomyelitis[3] offers any advantages over chronic fatigue syndrome, as it also has a broad definition. There is considerable symptomatic overlap with other conditions of fatigue, and a viral or infective aetiology cannot be established in all cases.[4,5] However, as research is relatively new in this field, an open mind should be kept as to whether myalgic encephalomyelitis represents a unique subgroup of chronic fatigue syndrome. Chronic fatigue syndrome may refer to heterogeneous conditions of fatigue, but this is also true of the term myalgic encephalomyelitis. We have recently commented on some of the shortcomings of the various chronic fatigue syndrome criteria.[6] Goudsmit and colleagues are justified in pointing out the lack of attention paid to qualitative differences in fatigue in various conditions. These may be more important than presently acknowledged and are not addressed in the definition of chronic fatigue syndrome. Our preliminary findings of follow up of over 60 patients with chronic fatigue syndrome and depression indicate that there may be some phenomenological differences in the fatigue in major depression and in chronic fatigue syndrome.[7]

We fail to see how the term chronic fatigue syndrome trivializes a condition — the word 'chronic' conjures up a picture of poor outcome. We are concerned that Goudsmit and colleagues feel that any value judgement of sufferers and particularly of aetiology is implied in the term chronic fatigue syndrome.

Secondly, there are difficulties in the assessment of depression and we have therefore emphasized the use of psychic features, such as pessimism, since these have been shown to be more useful.[8] However, having these features on their own should not lead to a diagnosis of depression or other mood disorder — severity and duration of symptoms need to be considered.

Central to the debate is what is meant by depression. Goudsmit and colleagues refer to 'true clinical depression', but there are many forms of affective disorder including 'reactive', 'endogenous', 'atypical' and 'masked' depression. Severe depression with pronounced biological symptoms is rare in chronic fatigue syndrome, but it is also rare nowadays in psychiatric practice. More of the depression seen in chronic fatigue syndrome is of the 'reactive' type of mild to moderate severity. Reactive depressions may become chronic and are also disabling.

Finally, regarding treatment, the paper acknowledged that antidepressant drugs are only one potential treatment for