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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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

depressive symptoms in chronic fatigue syndrome. The anecdotal reports of side effects of antidepressant drugs used in chronic fatigue syndrome patients are insufficient evidence to damn a potentially useful treatment for depressive symptoms, bearing in mind the risks of leaving a concurrent reactive depression untreated, and of suicide risk in what is acknowledged to be a chronic condition. We are not aware of any case where antidepressant drugs have caused a permanent adverse outcome regarding chronic fatigue syndrome. Response and how well the treatment is tolerated depend on many factors, but with careful assessment and selection,[1] chronic fatigue syndrome patients with concurrent depression of moderate severity usually benefit from treatment with the newer, less sedative antidepressant drugs.

Regarding spontaneous recovery, the patients treated in our studies had concurrent major depression, and in over 50% this was present for several months before treatment. Twenty five patients with similar symptoms and characteristics who refused antidepressant treatment (and were offered cognitive therapy) tended to have a longer duration of depressive symptoms which were more severe than the group treated with antidepressant drugs. These findings would tend to argue against spontaneous recovery but of course it cannot be excluded.

Several centres in the United Kingdom are now undertaking controlled trials of antidepressant drugs in chronic fatigue syndrome and until the results are known clinicians may need to try treatments for chronic fatigue syndrome on an open basis (including antidepressant drugs) to alleviate suffering.

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Patient satisfaction and style of practice

Sir,
Dr Johnson's letter (September *Journal,* p.386) should lead us all to reflect on patient satisfaction. Measurement of patient satisfaction is not a new concept in general practice but can it influence doctor behaviour?

In 1984 I was a trainee in a practice in the south west of England. The practice had a reputation for quality, fulfilling all the objective measures of quality as promoted by the Royal College of General Practitioners in terms of records system, practice management and medical protocols. All the partners were RCGP members. I attempted to measure patient satisfaction by questionnaire, using selected criteria from the RCGP working party report 'What sort of doctor?'.[1]

All 572 patients over 18 years of age attending the practice in a one week period were asked to complete a questionnaire. A total of 189 replies were received (33% response rate). The replies revealed that 99% of respondents knew with whom they were registered and that 79% felt that they 'had a special relationship with their own doctor'. Of the respondents 95% felt that the doctor should encourage them to look after their own health and 87% felt that their doctor did this. Only 4% of respondents thought there was a remote possibility that the doctor might pass on any confidential information. Sixty seven per cent of respondents felt that they could have an appointment to see the doctor at the surgery, and 80% a home visit, at any time.

With hindsight I can see many faults with my survey but it was the general message that most influenced me. The patients seemed more than satisfied and many volunteered words of praise on their questionnaires. This project marked a turning point in my general practice aspirations. This practice was to be the benchmark for my future career. I wonder if, seven years on, I would have the courage to repeat the study in my own practice?

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Reflotron measurement of blood cholesterol

Sir,
I read with interest the letter by Curzio and colleagues (October *Journal,* p.433). The results they obtained in their comparison of Reflotron® (Boehringer) and laboratory measurements of blood cholesterol were disappointing.

Previous studies have generally achieved correlation coefficients of approximately 0.95, and a mean difference and standard deviation of less than 0.5 mmol^{-1}.[1-3] Operator training is known to have a major impact on accuracy of Reflotron measurements.[4] The poor Reflotron performance may have been due to inadequate training of the operators and/or a poor system of quality control. Additionally, no mention was made of how the accuracy of the laboratory measurements was determined. It is therefore difficult to determine what proportion of the poor Reflotron performance was in fact attributable to laboratory error.

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Reaccreditation of GPs

Sir,
Accreditation and reaccreditation of general practitioners are topical issues. It is my hope that these issues will be linked to fundamental changes in postgraduate education, making the content of hospital posts in the vocational training scheme more sensitive to the needs of future general practitioners, and permitting educational assessment of general practitioners as individuals and within the context of the primary health care team.

To achieve this, the core of a training scheme should perhaps include training in psychiatry and geriatric medicine, the