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.

SEAN LYNCH
STUART MONTGOMERY

St Mary's Hospital Medical School
London

RAM SETH

Dulwich Hospital
London

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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?

DOMHNALL MACAULEY

33 Stewartstown Road
Belfast BT11 9FZ

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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.

F A MAJEED

Rikenel
Montpellier
Gloucester GL1 1LY

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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