Both my approach and that of Sharpe and colleagues recognise that negative mood states and social problems must be dealt with. Another common aspect of management is that emphasis is on a "collaborative rather than an adversarial approach." A turning point is often when a patient develops confidence and starts to feel able to exert some control over the illness.³ At this stage energy levels are higher and activity also increases, but I do not recommend an emphasis on greater activity until a patient feels 80% normal.³

I believe that the patients' beliefs about the chronic fatigue syndrome—that it was mainly physical, was caused by a virus, or was myalgic encephalomyelitis—were not a major factor in the improvement of Sharpe and colleagues' patients. It was probably far more important that there was collaboration to deal with the patients' problems with a definite regimen, regular appointments, and clear objectives.

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Authors' reply

EDITOR,—We addressed a clinical question of practical importance to ourselves and our colleagues—namely, could we improve the disability and fatigue of patients referred to a hospital clinic with severe medically unexplained fatigue (the chronic fatigue syndrome)? The available evidence indicated that the prognosis for these patients was poor¹ and (contrary to S A Chilton's suggestion) that there were no treatments of proved and accepted effectiveness.^{2,3} We chose cognitive behaviour therapy because it is effective in related conditions⁴ and because (for reasons given in the paper) we did not agree with Charles Shepherd's suggestion that its application to the chronic fatigue syndrome has been adequately evaluated. We chose to compare this therapy with sympathetic medical care from physicians experienced in assessing the syndrome as this is the best care available to most patients referred to hospital. Our results clearly show that patients who received cognitive behaviour therapy improved substantially more than those who were given only medical care.

Many of the methodological points raised by the correspondents were addressed in our original paper. Several correspondents ask, however, whether a simpler or alternative intervention might not have produced a similar benefit when compared with simple medical care. We agree that both replication of our result and the evaluation of alternative approaches are needed. Some data are already available. Colleagues at King's College Hospital, London, recently compared a similar form of cognitive behaviour therapy with a relaxation treatment matched for time (A Deale *et al*, world congress of cognitive and behavioural therapies, Copenhagen, Denmark, Jul 1995). They found that the cognitive behaviour therapy was substantially more effective, which suggests that neither simple attention

nor relaxation treatment is adequate for this condition. We agree with the correspondents who suggest that the next steps for research should include identification of the effective ingredients of cognitive behaviour therapy and the delineation of factors relating to the patient that predict a good response.

Shepherd, Ray Gibbons and colleagues, and K K Eaton all suggest that we neglected the biological component of our patients' illness. In fact (and contrary to Stephen M Lawrie's selective quotation), we take an explicitly biopsychosocial view of the chronic fatigue syndrome. We have been at pains to point out that the relative effectiveness of cognitive behaviour therapy does not mean that the illness is "all in the mind." While biological factors are likely to be important, however, their precise nature remains uncertain.

Many more questions still need answers: Gibbons and colleagues ask whether cognitive behaviour therapy is effective for extremely disabled patients, Shepherd suggests that homeopathy can work as well, and D O Ho-Yen speculates that his treatment has a similar effectiveness. We hope that these questions will be addressed in randomised controlled trials as only in this way will it be possible to adopt an evidence based approach to treatment. For the time being, intensive and individually tailored cognitive behaviour therapy is one of the few approaches that has been found to help most patients attending hospital outpatient clinics with this chronic and disabling illness.

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Tobacco funding for academics

A public relations disaster

EDITOR,—We write to express our profound dismay and concern at the news that Cambridge will accept £1.5m from the British American Tobacco Company to establish a chair of international relations.¹

From our perspective this is a public relations disaster and a blow to public health advocacy for tobacco control. You are presumably aware that the transnational tobacco companies, such as BAT, are targeting children and young women in the Asia Pacific region. Purpose designed advertising and other promotional activities are successfully recruiting large numbers of young people to smoking in this region, with disastrous consequences for their health. We regard tobacco related disease as the principal threat to the health of Asia Pacific communities now and in the future. The revenue from which the Cambridge chair will partly be funded has been generated from sales which are leading to the commonest registered causes of death, the commonest causes of morbidity, and the greatest

health care demand and health care costs in this Territory, the People's Republic of China, and other Pacific rim countries.

We are astonished that the prestige and status accorded by a named chair in Cambridge can be bought so cheaply by an organisation whose product injures or kills at least half of those who use it as intended.

Finally, what are the implications of this sponsorship for academic freedom in Cambridge? For example, in 1993 the Thai government's efforts to control the importation of American tobacco and protect the health of its population was dealt with very effectively by the industry. They brought in Senator Robert Dole to threaten the Thais with trade sanctions. The nefarious activities of the tobacco industry in this region and other parts of the world are ruthless and disgraceful. Yet we note that the industry is to be given a say in the selection of staff and students in Cambridge university. In the circumstances, would the impact of transnational tobacco companies on governments' policies, trade, and international relations be a subject eligible for academic research and discourse in Cambridge's new unit?

We respectfully urge Cambridge to reject this proposal and to dissociate itself from this form of patronage by the tobacco industry.

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Buying respectability

EDITOR,—Cambridge University's proposed acceptance of funding for a chair from the tobacco conglomerate BAT (British American Tobacco)¹ invites questions about whether there are any benefactors from whom the university would not consider accepting such funding.

It is not inconceivable that a pornographic consortium might seek to fund a chair in erotic literature, the Libyan or Iraqi governments to fund chairs in counterinsurgency, or Zaire's disgustingly wealthy President Mobutu to fund a chair in community development. Money is no object to such groups, but respectability and decency are qualities they crave on the international stage. As the chief executive of Brown and Williamson (BAT's subsidiary in the United States) said to Congress in 1994, "Congressman, it's hard for me to envision becoming more of an outcast than I am."

Plainly, there are standards beneath which an esteemed university would not venture. Yet by colluding with a tobacco company's desire to buy respectability, Cambridge will send a message to the world that tobacco companies deserve such respect. Dr Richard Hurt recently wrote about the push by companies such as BAT into Russia: "Stalin was a ruthless dictator who caused the death of millions of Russians. Although his reign of power lasted for more than 25 years, it had a finite duration and was confined to the 20th century. The death and disability that will be caused by the use of Western tobacco products are just beginning and will continue for many decades. Stalin may have intentionally ordered many of his victims to be killed, but most died as a result of his policies, which were intended to accomplish strategic and political goals. For Western tobacco companies, death is simply the most pronounced by-product of the use of their

products....Although Stalin had a sophisticated propaganda machine for its time, the tobacco industry is using the most advanced technology available to produce a 21st-century propaganda effort. Stalin's methods were perceived as cold and calculating, but those of the tobacco industry are smooth and subtle. The marketing plans are prospective, with the result of pervasively infiltrating all facets of Russian life."²

I find Hurt's analogy entirely apt, and I urge Cambridge most earnestly to deny BAT an honour which will lower the esteem in which Cambridge is held throughout the world.

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Cheese and salmonella infection

Distribution and retail of cheese, not just production, may lead to contamination

EDITOR,—Anita Rampling's editorial serves as a timely reminder of the dangers of consumption of cheeses made from raw milk.¹ Although she notes in passing that infection has also been associated with cheese made from pasteurised milk, we wish to re-emphasise the potential importance of such products in the epidemiology of human listeriosis. The protracted outbreak of listeriosis in Switzerland between 1963 and 1987, with 122 cases and a case fatality ratio of roughly 25%, was associated with cheese derived from pasteurised milk that had been contaminated during production.² Additionally, Bind reported that cheeses made from pasteurised milk are just as likely to be contaminated with *Listeria monocytogenes* as are those manufactured from raw milk.³ Although contamination of pasteurised milk cheeses can occur at any stage during the production process, the possibility of contamination in the retail environment is often overlooked.

After an invitation to examine a variety of soft cheeses from a specialist outlet we found that, of 11 samples from 10 brands, six grew *L. monocytogenes*, with two yielding counts in excess of 10⁶ colony forming units/g. A repeat sampling exercise yielded a similar frequency of contamination. The retailer accepted cheese for sale only if a batch was accompanied by a certificate from a microbiology laboratory attesting that the cheese was free of listeria. Accordingly, samples of one brand found to be heavily contaminated were sent direct to our laboratory, but they did not yield *Listeria* spp on direct or enrichment culture. A portion of the sample was held at 4°C for one month, retested, and again found to be free of listeria. On a subsequent visit to the retailer's premises it was noted that the cheeses were displayed unwrapped on a bed of straw, material from which has been shown to be contaminated with *Listeria* spp. Requests to sample this, however, were denied. Currently we are typing these isolates of *L. monocytogenes* by random amplification of polymorphic DNA by the polymerase chain reaction⁴ to examine the possibility that the straw may have acted as a reservoir for contamination with this bacterium.

We agree with Rampling that food manufacturers strive to ensure that their produce is microbiologically safe, but those who distribute and retail products after they leave the factory must acknowledge that they too have responsi-

bilities if the consumer is to be fully protected against foodborne disease.

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Cheese lovers should not be condemned to a pasteurised and tasteless product

EDITOR,—Anita Rampling's editorial will have struck a chill in the hearts of many food lovers.¹ Her suggestion that, with pasteurisation as the first stage of production of all milk products, "all cheeses could be relied upon as delicious ...foods" does not stand up to scrutiny. If acted on it would deprive us of much that is delicious.

While I would not question Rampling's knowledge about outbreaks of food poisoning, I would challenge her assertions that "many cheese makers who produce prize winning gourmet cheeses use pasteurised milk" and that pasteurisation eliminates "bacteria and yeasts which may spoil the flavour." Davis, the author of a magnum opus on cheese, states that "raw milk cheese nearly always has a fuller flavour than pasteurised milk cheese."² The great cheese guru, Rance, reported how he found the plummeting sales of one particular cheese inexplicable until he learnt that the producer had switched to pasteurised milk. At Wells Stores in Abingdon, the cheese shop founded by Rance, more than half of the list of over 120 British and French cheeses is made from unpasteurised milk. A double blind tasting would quickly show which are the more delicious.

Already food hygiene regulations mean that cheese served in many restaurants is too cold to be enjoyed; we do not need any further intrusions into our pleasure. Of course food poisoning is serious, particularly when deaths occur, but outbreaks due to cheese are extremely rare and must pale into insignificance when compared with those due to "factory chicken." The answer is surely to increase hygiene and testing among milk producers rather than to condemn cheese lovers to a pasteurised and tasteless product.

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All milk products should be heat treated

EDITOR,—We support Anita Rampling's recommendation that pasteurisation should be the first

stage in the production of all milk products.¹ The European directive 92/46/EEC sets standards for raw milk, heat treated milk, and milk based products. While the directive sets microbiological criteria for certain milk based products, member states may grant derogations from the regulations. The enforcing Dairy Products (Hygiene) (Scotland) Regulations 1995 make it possible for "milk-based products with traditional characteristics" to be given a derogation. Such derogations are illogical and endanger public health.

In Scotland the fitness of a batch of a particular cheese for human consumption has recently been tested in the courts.² *Listeria monocytogenes* was identified in retail samples, and a condemnation order under section 9(6) of the Food Safety Act 1990 was sought. This was the only legislative route open to the enforcing authority as, though the cheese did not meet the terms of the directive, the regulations of 1995 were not then in place. The order was refused, the sheriff finding that "the evidence did not support the claim that all strains of *L. monocytogenes* should be regarded as potentially dangerous—and hence, likely to be injurious to health." If the presence of potentially pathogenic organisms in a cheese, determined by best professional advice, is not sufficient proof of a risk to health for legal purposes, where does this leave local authorities as enforcement agencies under the act, and health boards and health authorities as their medical advisers? Is the proof of human disease required before intervention can take place?

While some pathogens are inactivated during the cheese making process, others survive or increase; whether they do so is determined by the microbiological, biochemical, and physical properties of the particular cheese. Thus the manufacturing process itself, despite the application of risk assessment, cannot be guaranteed to produce a product free of pathogens without prior pasteurisation. Cheeses, especially traditional cheeses, are often sold in outlets or restaurants where a health warning is impractical. Informed choice is therefore not possible. In Scotland pasteurisation of cows' milk that is for sale has been compulsory since 1983. Outbreaks associated with milk (other than those due to the failure of plant or avoidance of treatment) have ended. The present position places the public's health in jeopardy. Pasteurisation, or similar heat treatment, should be used for all milk products sold for human consumption, however produced.

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Exceptional cheeses can be made only from raw milk

EDITOR,—While Jean-Claude Desenclos and colleagues' article on an outbreak of *Salmonella enterica* serotype *paratyphi B* infection caused by a goats' milk cheese is factual,¹ Anita Rampling's editorial draws unjustified conclusions and contains contentious assertions.² Rampling asks, "Is the notion that raw milk cheese tastes better just a myth?" Desenclos and colleagues say, "In