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.

D O HO-YEN
Consultant microbiologist

Microbiology Department,
Raigmore Hospital NHS Trust,
Inverness IV2 3UJ

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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.

MICHAEL SHARPE

Clinical tutor

KEITH HAWTON

Senior clinical lecturer

Department of Psychiatry,
University of Oxford,
Warneford Hospital,
Oxford OX3 7JX

TIM PETO

Consultant physician

Nuffield Department of Medicine,
John Radcliffe Hospital,
Oxford OX3 9DU

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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.

A J HEDLEY C L BETSON

Professor of community medicine Lecturer

T H LAM R M HARDIE

Reader Lecturer

R FIELDING S M MCGHEE

Head, behavioural sciences unit Lecturer

Department of Community Medicine and Unit for Behavioural Sciences,
University of Hong Kong,
Hong Kong

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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