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<th><strong>Title</strong></th>
<th>Tobacco funding for academics. A public relations disaster.</th>
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Both my approach and that of Sharpe and colleagues, who pointed out 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 the patient develops confidence and starts to feel able to exert some control over the illness. 

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.

I believe that the patients' beliefs about the chronic fatigue syndrome—that it was mainly physical, was caused by a virus, or was myalgic encephalopathy—were a therapy 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 poor and (contrary to S A Chilton's suggestion) that there were no treatments of proved and accepted effectiveness. We chose cognitive behaviour therapy because it is a similar form of treatment conditions and because (for reasons given in the paper) we did not agree with Charles Shephard'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 above syndrome are addressed in our original paper. Several commentators 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 patients in a similar 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, in Shephard & Deere'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 it has a similar effect. 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, interested and carefully 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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**Buying responsibility**

**EDITOR.**—Cambridge University's proposed acceptance of funding for a chair from the tobacco conglomerate BAT (British American Tobacco) 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 government to fund a chair in Middle Eastern politics, or Zaire's dishonestly wealthy President Mobutu to fund a chair in community development. Money is no object to such groups, but respectability and decency are qualities that rarely come 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 that it is in the pocket of rich, and for 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 that rarely come 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."

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 activities and promotional marketing 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 commencement of millions of deaths, the commonest causes of morbidity, and the greatest