**Chronic Fatigue Syndrome/Myalgic Encephalopathy – Disagreement, Uncertainty, Distress, Authority and Obligation.**

There is bitter disagreement between medical authorities and patient advocacy groups regarding the management of chronic fatigue syndrome/myalgic encephalopathy (CFS/ME).1 These disagreements are related to uncertainties and areas of ignorance about the condition: there is no known agreed cause for its onset or for its continuing symptoms; and there is no test that shows that any alleged mechanism is present in more than a minority of patients.2 The treatment for any condition should be based on evidence regarding its causative mechanisms, or at least on the success of the treatment. But, in CFS/ME there is no known curative treatment; and symptomatic treatments have limited success.

CFS/ME patients find that mental or physical exercise beyond their limits worsens their symptoms. Their understanding is therefore that too much exercise is harmful. So, their symptomatic self-treatment (as supported by CFS/ME patient advocacy groups) is ‘pacing’ - exertion only within limits, followed by deliberate rest.3 By contrast, the British National Institute for Health and Care Excellence (NICE) recommends graded exercise therapy (GET) and cognitive behaviour therapy (CBT).4 Many CFS/ME patients complain that their doctors impose these treatments against their wishes. These patients interpret the rationale behind recommendations for GET, that CFS/ME is due to or exacerbated by deconditioning or physical unfitness, as being unfairly critical of their response to their illness. And they interpret CBT as telling them that there are things wrong with their mind, that they have a ‘mental’ illness not a physical one. Many CSF/ME patients and their advocacy groups find the imposition of CBT and GET as disparaging and distressing, and they find that GET and CBT make their symptoms worse.1

Our response to these disagreements should commence with obtaining some understanding of the opposing standpoints. The different treatment recommendations highlighted above are justified by seemingly incompatible conceptualisations of disease, the biopsychosocial model (BPS) and the biomedical model (BMM).5 Medical researchers and some philosophically-minded clinicians support BPS as justification for GET and CBT, and reject BMM as inadequate;6 while CFS/ME advocates and some phenomenological and hermeneutical philosophers reject BPS and support the use of BMM.1,2 The opponents in this dispute each share a dislike of medical mind-body dualism and reductionism, but they both accuse each other of being guilty of these solecisms.1,5 This presentation shows that these disagreements are associated with the attribution of different meanings to these terms by the protagonists.

But who should be the authorities here, patients and their supporters or medical researchers and doctors? For phenomenological and hermeneutical philosophers, patients’ experience, understanding, and interpretation are paramount. But neither hermeneutics nor phenomenology seem to have methodologies to resolve the tension when there is a difference between a doctor’s and a patient’s conceptualisation of an illness and its treatments (and nor does the biopsychosocial approach). However, within a consultation with a patient, the doctor has an obligation to attempt this resolution.

**Abbreviated Reference List**

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