come such a powerful tool. Examples of perinatal trials using cluster randomization include studies of counts of fetal movement in the prevention of antepartum stillbirth,[7] of early breast-feeding to prevent postpartum hemorrhage[8] and of counselling for smoking cessation in prenatal care,[1] as well as a WHO-sponsored evaluation of a new model of prenatal care.[9] My colleagues and I are currently conducting a cluster-randomized evaluation (funded in part by Health Canada) of an intervention to promote breast-feeding based on the WHO/UNICEF Baby-Friendly Hospital Initiative. Cluster-randomized trials require highly trained research teams, large sample sizes and substantial funding. If individual-based interventions deserve rigorous methods of evaluation, the far larger number of individuals whose health and welfare may be affected argues for better, not worse, methods of evaluating community-based interventions.

I have no objection to funding truly "worthwhile interventions," whose effectiveness has been rigorously demonstrated. In the maternal–child health arena alone, postnatal support of breast-feeding, provision of automobile restraints and bicycle helmets, and improvement in vaccination coverage are public health promotion efforts whose scientific basis is far stronger than that of CPNP.

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What causes chronic fatigue?

Even though the 3 articles on chronic fatigue syndrome[1–3] in the Sept. 8 issue commendably demolish the obsolete claim that chronic fatigue syndrome is a psychiatric illness, they also offer outdated biological explanations for the syndrome, namely, either a chronic viral infection or a weakened immune system. Although the first of these explanations seemed convincing until a few years ago, it is hardly tenable now, because no specific virus has been identified in these patients.[4]

Both the viral reactivation and the immunological abnormalities observed in patients with chronic fatigue syndrome may well be accounted for by the cortisol deficiency that characterizes these patients.[5] This explanation is supported by the striking similarities between chronic fatigue syndrome and Addison's disease, which share 26 features,[6] including all of the neuropsychological symptoms.[5]

My conviction that chronic fatigue syndrome is an adrenal insufficiency similar to Addison's disease lies primarily in the fact that 4 years ago I recovered from chronic fatigue syndrome in the course of a few days thanks to the consumption of licorice,[7] with which addisonian patients were successfully treated before hydrocortisone and fludrocortisone became available.[7] These steroids, which currently represent the lifelong therapy for Addison's disease,[7] should be investigated in the treatment of patients with "true" chronic fatigue syndrome, as diagnosed according to the original criteria.[8] Conversely, patients in whom chronic fatigue syndrome is diagnosed on the basis of subsequent revised criteria[9] (which do not include the only physical signs — enlarged lymph nodes, fever and sore throat — that clearly distinguish chronic fatigue syndrome from depression) should avoid both steroid replacement therapy and licorice. In fact, depressed patients misdiagnosed as having chronic fatigue syndrome have abnormally high cortisol levels,[10] instead of the abnormally low cortisol levels found in patients with "true" chronic fatigue syndrome.[10] Therefore, administration of licorice or hydrocortisone would further increase their already-high cortisol levels.[7]

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The 3 excellent articles on chronic fatigue syndrome[1–3] reminded me of the desperate need for a discussion of the ethics — or lack thereof — related to independent medical examinations of patients with this condition.

A recent 21-page report from an independent medical examination of one of my patients with chronic fatigue syndrome included 2 pages of error-riddled history and the results of only a cursory physical exam, along with a bold admission that a full physical examination had not been done. The other 19 pages, clearly based on a word-processor template, were peppered with such clichés as "illness-seeking behaviour," "somatization syndromes" and "preconscious motives." The fee assessed for this report was $1200.

I used to be asked by insurance companies to perform independent medical examinations (for the standard fee suggested by the Alberta Medical Association), requests that I always accepted. However, when it became known that, in appropriate circumstances, I might support a diagnosis of chronic fatigue syndrome, such requests ceased abruptly.

The 3 *CMAJ* articles summarize the growing evidence that chronic fatigue syndrome is an organic illness of some kind. Yet many physicians who do independent medical examinations seem to be innocent of this evidence — or perhaps they simply ignore it. Despite the waiver of examiner responsibility for benefit or claim decisions, a physician reporting to a third party in fact shoulders a dual duty: first, to tell the truth, and second, to consider how this information will be used. If the bill for an independent exam is 10 times the usual consulting fee and the report presents a judgement of questionable quality that merely enables an insurance company to discontinue disability payments, the physician is in a position of serious conflict of interest.

Does our sense of honesty not demand that we disqualify ourselves from doing examinations for which we are unqualified? Will it become necessary for the provincial colleges to establish clearcut standards for physicians wishing to work as independent examiners?

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Correction

In The Left Atrium article describing the Life Quilt for Breast Cancer,[1] incorrect telephone and fax numbers were given. The Life Quilt organizers can be reached by telephone at 604 301-1184 and by fax at 604 301-1114.

Reference
1. Todkill AM. Fabric of hope: the Life Quilt for Breast Cancer. *CMAJ* 1999; 160(1):92-3.