Professor Subodh Dave FRCPsych
President, Royal College of Psychiatrists
Dr Lade Smith CBE
Immediate Past President, Royal College of Psychiatrists
12 July 2026

Dear Professor Dave and Dr Smith,

Thank you for your reply of 12 June 2026 to the open letter led by Long Covid Advocacy. The Cambridgeshire, Suffolk and Bury & Bolton groups are grateful for your engagement. We must, however, respond, because the reply's central justification — your emphasis on the "expert" use of the biopsychosocial model — does not resolve our concern but illustrates it. We intend this reply also to be open.

The framing of ME, and more recently Long Covid, as the product of mistaken illness beliefs sustained by physical deconditioning, and therefore remediable by behavioural and exercise interventions, is not new. It can be traced to the reinterpretation of the 1955 Royal Free Hospital outbreak as "epidemic hysteria" by McEvedy and Beard in 1970, and it has been developed and promoted over the subsequent half-century by a small and consistent group of clinicians, including figures named in our earlier letter. It is important to be clear about what this is: a specific, empirical theory. It makes claims about causation and about the effect of treatment, and those claims are testable.

They have been tested, and they have not survived. When NICE reviewed the evidence for guideline NG206 (2021), the trial evidence underpinning cognitive behavioural therapy and graded exercise therapy as treatments was assessed, under the GRADE system, as of low or — for the majority of outcomes — very low quality. The guideline recommends against graded exercise therapy as a treatment and no longer presents CBT as curative, positioning it only as supportive. Alongside this, patient surveys conducted over many years have recorded large numbers of reports of deterioration following graded exercise — consistent with post-exertional malaise, the cardinal feature of the disease and precisely the phenomenon that a deconditioning model cannot accommodate. ME is classified by the World Health Organization as a neurological disorder (ICD-10 G93.3).

Confronted with this, proponents have increasingly presented these ideas not as the specific deconditioning-and-beliefs theory they are, but as an application of the "biopsychosocial model." This is where the emphasis of your reply is, with respect, revealing. The biopsychosocial model, as proposed by Engel in 1977, is a heuristic — an orienting reminder that biological, psychological and social factors may all bear on illness. It is not a scientific theory. It makes no specific, falsifiable predictions; it excludes no possible observation; and it therefore carries no evidential weight of its own. One cannot, in any meaningful sense, be an "expert" in deploying an unfalsifiable framework to settle a question of biological fact. A framework that cannot itself be tested cannot lend evidential support to a specific theory that has failed when it was tested. To invoke it for that purpose is not a scientific argument but a rhetorical one.

We would add four observations on the specific points in your reply. First, that the session passed the same independent scoring process as others is a claim about procedure, not about content; procedural fairness and evidential accuracy are different questions, and a fair process can still produce a programme that misrepresents the evidence. Second, the description of the speakers as

“experts in their respective fields” elides the distinction between expertise and investment: Professor Chalder, for instance, is a co-author of a 2023 paper attacking the review methodology behind NG206, and has continued since to describe cognitive behavioural therapy and graded exercise as “evidence-based” treatments for this illness in terms that go beyond what the guideline concluded. A person may be a genuine expert in a field and, at the same time, one of the principal advocates for the position the field’s regulator has just rejected; presenting such a person to delegates as a neutral authority, without noting the conflict, is not balance. Third, the suggestion that declining to platform this theory risks “stigmatising patients who could benefit from [psychiatric] care” answers a claim nobody has made — that psychiatric care is shameful — in place of the claim we did make, that ME and Long Covid are not, on the current evidence, psychiatric conditions; this is not a rebuttal but a substitution. Fourth, the disclaimer that speakers’ views are their own does not touch the point at issue: the College still chose whom to platform and how to sequence and frame them, and curation confers endorsement whatever caveat is attached to it. We labour these points because together they show a pattern which is itself telling: a claim that can be defended on its own, specific terms does not need this kind of chaperoning by safer, adjacent ones.

The persistence of this paradigm is not merely an academic error. It has caused direct clinical harm to patients, as the NICE evidence review itself acknowledges. It has also done subtler and more serious damage: by characterising these illnesses as behavioural, it has for decades diverted attention and funding away from biomedical investigation and rendered the field one that researchers have been reluctant to enter for fear of reputational cost. More than seventy years after the Royal Free outbreak, there is still no diagnostic test and no curative treatment. That this is at last beginning to change owes nothing to the behavioural model. The DecodeME study (2025) — the world’s largest genetic study of ME/CFS, funded by the Medical Research Council and the National Institute for Health and Care Research — has identified eight genetic signals associated with the disease, implicating immune and neurological mechanisms, and found no shared genetic basis with depression or anxiety. One cannot believe one’s way into a genome.

In short, an unfounded and demonstrably harmful theory continues to shape the medical establishment’s thinking on these illnesses and is causing serious harm both to patients and to the progress of research. The College is in a position to do much to correct this. We ask that it cease to lend such theories the prestige of “expertise” and the shelter of an unfalsifiable framework; that it align its programming and outputs with NICE guideline NG206 and the current biomedical evidence base; and that it ensure these conditions are not presented through interpretive models with little or no evidence to support them.

Yours sincerely,

Dr Mark Harper, corresponding author
Cambridgeshire ME and Long Covid Support Group

https://cambridgeme.org.uk
https://www.facebook.com/CBMEgroup
@cbme-mark.bsky.social

Co-signed by:

Suffolk Youth & Parent ME Support Group
Bury & Bolton ME/CFS & Fibromyalgia Support Group