Before undertaking specialist learning on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), my understanding was limited to viewing it as a chronic fatigue condition with unclear biomedical origins. The most important learning point for me has been recognising post-exertional malaise (PEM) as the defining feature of ME/CFS — a delayed and disproportionate worsening of symptoms following minimal physical, cognitive, or emotional activity. This transformed my perception of ME/CFS from vague fatigue to a severe multisystem disease with significant functional consequences.

ME/CFS causes disabling fatigue, cognitive impairment, pain, sleep disturbance, and autonomic dysfunction; however, PEM uniquely distinguishes it from other fatigue-related illnesses (Institute of Medicine, 2015). Biomedical research increasingly validates a biological basis for the condition. Patients demonstrate immune abnormalities such as reduced natural killer cell function (Hardcastle et al., 2015), neuroinflammation on PET imaging (Nakatomi et al., 2014), autonomic dysfunction including orthostatic intolerance (Raj et al., 2020), and impaired cellular energy production involving mitochondrial pathways (Che et al., 2021). This evidence challenges historical misconceptions that symptoms arise from deconditioning or psychological distress.

Understanding PEM has changed how I view rehabilitation. While graded exercise therapy was once recommended, evidence shows that forcing increased activity can trigger relapse and clinical deterioration (Vink and Vink-Niese, 2020). Instead, pacing, activity management, and prioritising energy conservation are key to supporting patients safely. Recognising that even routine daily tasks — brushing teeth, reading, socialising — may exceed a patient's energy threshold has strengthened my appreciation of the hidden severity of disability. Up to 25% of individuals may become housebound or bedbound (Pendergrast et al., 2016), resulting in profound isolation, loss of independence, and drastic reductions in quality of life.

The course additionally deepened my awareness of the illness trajectory. Around 75% of cases follow acute infection (Komaroff and Bateman, 2021). Research into Long COVID has accelerated recognition of post-viral syndromes and highlighted overlapping immune and autonomic abnormalities (Davis et al., 2023). This convergence is shifting healthcare attitudes, encouraging earlier diagnosis and more compassionate management.

Reflecting on my own development, I recognise that stigma and diagnostic uncertainty have contributed to widespread patient harm. Many individuals experience disbelief from clinicians, leading to delayed support and psychological trauma (Geraghty and Esmail, 2021). Going forward, I will ensure patients feel heard, validated, and supported from first presentation. Applying NICE-aligned care, collaboratively exploring coping strategies, and advocating for adjustments in education, employment, and social care are essential to preserving dignity.

In summary, learning about PEM and the growing biomedical evidence has reshaped my clinical approach. ME/CFS is a serious, complex illness that demands empathetic, evidence-based support. This knowledge will enable me, as a future doctor, to deliver safer care, challenge misconceptions, and advocate for continued research and recognition for people living with ME/CFS.

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