

**Composite Response on the Final Version of the CMO's Report of 31<sup>st</sup> August 2001 on CFS/ME edited by Professor Malcolm Hooper, Emeritus Professor of Medicinal Chemistry, University of Sunderland, SR2 7EE, UK** **29.09.2001**

The 140 page report of the UK Chief Medical Officer (CMO) on Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME) is now in its final version and has been sent to the CMO for approval. These comments relate to that version. The report refers to the "Working Group" throughout: this term refers to the combination of the three participating groups (the Key Group, the Children's Group and the Reference Group) and use of the composite term may imply consensus by the three groups. Such consensus was not achieved. Some claims made in the report on behalf of the "Working Group" as a whole are not endorsed by all members. There is in fact strong disagreement concerning issues relating to the nature and the management of the disorder. Initially, it was understood there would be provision for members of the Working Group to endorse or not endorse the final report as appropriate and there has been much discussion amongst at least two of the three patient groups' representatives as to whether or not they could endorse certain sections of the report, but it now transpires that no mechanism for endorsement will be available.

**re: CONTENTS LIST**

The main Contents list no longer includes a separate and easily identifiable chapter on "Diagnosis" as contained in previous drafts. Previous Contents lists included "Practical Guidance for Clinicians" (now omitted, as are "Establishing a diagnosis" and "Recognition of particular features"). Such omissions from the main Contents list are unhelpful to those seeking straightforward information; these sections now come under subsections of "Management" but this is not apparent from the Contents list.

**re: FOREWORD** (by Professor Allen Hutchinson, Chairman of the Working Group)

Whilst it is noted that the report awaits final proof reading, "FOREWORD" is spelt wrongly, which seems to indicate editorial carelessness. The eight members of the editorial team are listed on pp 90 / 91 and include Professor Tony Pinching (Deputy Chair of the CMO's Working Group) and Helen Wiggins of the NHS Executive.

The Foreword refers to CFS/ME being a unified entity with no mention of the issues involved; this sets the tone of the whole report and is misleading. It states that the Working Group "*sought to bring together knowledge on CFS/ME*" but much available knowledge has been dismissed and/or ignored, presumably to placate the dominant psychiatric faction known as the "Wessely School" whose members are well-represented in the Working Group. The disregarded but available knowledge has important implications for treatment / management. As addressing the management of the disorder is stated to be the key remit underlying this report, it could be expected to have been addressed with particular diligence but such is not the case.

**page 5: re: Chapter 1 INTRODUCTION**

From the first sentence CFS and ME (as in the Foreword) are amalgamated as a single entity with no discussion of the fact that there are two polarised interpretations of “CFS”, one of which relates to ME (ie. “CFS” as contained in the International Classification of Diseases which is virtually synonymous with ME and on which much of the international research has been carried out, revealing biomarkers in neuroendocrine-immunology, muscle function and neurovascular mechanisms), the other of which does not relate to ME /ICD CFS in any way (ie. the Wessely School psychiatric interpretation of “CFS”, which claims that sufferers have an “aberrant belief” in that they only *think* they have an physical disorder, which Wessely et al believe is a “behaviour” problem). Not to acknowledge these differing interpretations from the outset is deceptive and can only contribute to the existing confusion. As mentioned, these differences have important implications for management which, as the primary remit of the Working Group, need to be addressed with precision, not obfuscated further.

The various case definitions are listed in Appendix II on page 93 at the end of the main body of the report but the differences and variability in case definitions should have been made clear from the outset. There is no guidance for clinicians as to which case definition should be used, nor is there any discussion of the important fact that the Sharpe / Wessely definition of CFS (known as the 1991 Oxford criteria) expressly includes those with existing psychiatric illness: much of Wessely’s own work uses the Oxford criteria for case selection but the Oxford criteria have been criticised on the grounds that they have diluted and widened the inclusion criteria too much. Studies of “CFS” based on the Oxford definition are known to be looking at different patient populations, resulting in heterogeneity which confounds the results when compared with other studies. There is much concern in the medical literature about this confusion but no mention is made of it in the CMO’s report.

The Introduction states *“Where research evidence exists we have been guided by it”*. That sounds very reassuring and commendable, but the facts are that such a claim is known to be inaccurate, because compelling research evidence of biomarkers which indicate organic disease which was put before the Key Group (the decision-making group within the Working Group) has been consistently ignored in favour of emphasis and reliance upon non-organic factors (eg. illness beliefs and personality as perpetuating factors) when such factors are not supported by the international research evidence.

The Introduction repeats verbatim what was claimed in the Foreword (*“We found that it can and should be approached and managed clinically like any other chronic illness”*). To repeat this same phrase on consecutive pages seems to indicate careless editing.

The remit of the Working Group (boxed for impact) is stated as being *“To review management and practice in the field of CFS/ME”* and to *“make recommendations for further research into the care and treatment of people with CFS/ME”*. Until more is known about the aetiology of the disorder, how can it be a scientific, “evidence-based”

approach to look only at treatment / management but to ignore the credible evidence which points towards pathology? As Anthony Komaroff (Professor of Medicine at Harvard and an acknowledged world expert on ME/ICD CFS) has noted: **“To come up with really good treatment, you need to understand more about the causes”** (*ref: Co-Cure, 24 September 2001*). Who is accountable for the narrowness of the Working Group’s remit? Such expedient terms of reference imposed constraints and restrictions which guaranteed that the real issues would not be addressed, resulting in a continuing additional burden for those already struggling with an overwhelming illness.

page 6 para 1.2 (Policy context)

The Joint Royal Colleges’ report on CFS was published in October 1996 (not in May 1996 as here stated, which again indicates careless editing). It did not *“provide a starting point to inform medical opinion”* as claimed in the CMO’s report. It was unequivocally shown to be inaccurate, selective, scientifically flawed and heavily biased (*ref: The Royal Colleges’ Report on CFS: Insidiously Biased and Potentially Harmful. TE Hedrick. CFIDS Chronicle 1997:10:1:8-13*): the authors of that report (the most influential being also involved with the present report) cited references in apparent support of their own beliefs when the referenced papers themselves concluded the exact opposite. Does that not amount to scientific misconduct? Should such conduct be described in the CMO’s report as *“informing medical opinion”* when in reality it mis-informed medical opinion? Unless these issues are exposed and openly addressed, the perpetuation of mis-information is implicitly condoned (to the serious detriment of vulnerable patients) and accountability for this may ultimately rest with the CMO himself.

The 1994 National Task Force Report was not looking at *“Myalgic Encephalitis”* as claimed in the CMO’s report (more editorial carelessness).

page 8/9 para 1.3.3 (Development of the report)

It is noted with concern that the report states that where disagreements persist within the Working Group, it is *“the likely resource implications”* which have informed the report conclusions. Should it not be **medical science** which informs the report conclusions? Such an admission is however in line with the recommendations of the 1996 Joint Royal Colleges’ report on CFS. In that report, ME is dismissed: despite being documented in the medical literature since 1934, the authors assert at 13.3 that *“Previous studies have counted people with ME, but these studies reflect those who seek treatment rather than those who suffer the symptoms”* (therefore the authors can claim with impunity that there can be no cost implications for a *“non-existent”* disorder), whilst for CFS (in the authors’ view, a psychiatric condition with no physical signs), they assert that no service provision is necessary apart from cognitive behavioural therapy, which the authors claim is cost effective and therefore attractive to the cash-strapped NHS. (The validity of psychiatric trials and the cost-effectiveness of CBT has been challenged by Tony Johnson of the MRC Biostatistics Unit at Cambridge in a critical analysis of the methodology of psychiatric trials, who found that a course of psychotherapy typically lasts for 12 weeks

and a major limitation is its cost (*ref: Clinical trials in psychiatry: background and statistical perspectives. T Johnson. Statistical Methods in Medical Research 1998:7:209-234*).

page 9 para 1.4 (Clinical context)

This report states *“To review management and practice of any clinical condition, certain questions must first be answered: What is the condition under review? ....Thus an early step in our process was to review available evidence on definitions and terminology....”* and readers are referred to Annexes I - 3. The seven On-line Annexes are intended for professional use; not only are some of them factually wrong in several respects (see comments on Annexes below) but they may not be available to those without access to the internet. In some respects, the content of the report itself and the content of the Annexes differ.

page 10 para 1.4.1 (Definitions and terminology)

It is important to be aware that the two most commonly used case definitions of CFS ( the 1991 Oxford criteria and the 1994 US Centres for Disease Control [CDC] criteria) both exclude patients who have any physical signs: the 1994 CDC criteria (in the formulation of which both Michael Sharpe and Wessely were involved, as they were in the Oxford 1991 criteria) specifically state *“We dropped all physical signs from our inclusion criteria”*. It is a matter of note that the CMO’s report fails to point this out either in the text or in Appendix II on page 93, nor does it inform readers that those with ME / ICD CFS always have observable physical signs. This is a very important issue which in an increasingly well- informed and litigious society clinicians ignore at their peril, because it has an impact on management and outcome.

The CMO’s report states *“Currently, CFS and ME are classified as distinct illnesses in the World Health Organisation’s International Classification of Diseases”*. **Not only does the report fail to clarify that ME is formally classified by the World Health Organisation as a neurological disorder in the International Classification of Diseases (where it has been so classified since 1969 in ICD revision 8), this statement is intrinsically erroneous.** Together with postviral fatigue syndrome (PVFS), chronic fatigue syndrome (CFS) is listed as one of the names by which ME is sometimes known in ICD 10 at section G93.3 (Disorders of the Nervous System). **In contrast, chronic fatigue states (including neurasthenia) are listed at section F48.0 under Mental and Behavioural Disorders (Other Neurotic Disorders), from which section ME/PVFS/CFS is specifically excluded.** Chronic fatigue syndrome is not the same as any of the various chronic fatigue states.

To include such an erroneous assertion in the CMO’s report is either inexcusable editorial carelessness or it is deliberate propagation of mis-information in accordance with what appears to be a previously employed pre-determined agenda. Such misrepresentation is unacceptable in a Government report, where accuracy should be paramount.

Any pre-determined agenda may be related to the fact that the WHO neurological classification of ME is not accepted by Professor Wessely or by those who subscribe to his beliefs (whose views seem to dominate the Working Group). For well over a decade he has published his own belief that ME does not exist and that CFS is a psychiatric disorder. In 1993 he wrote in the *Lancet*:

“The inclusion in the tenth revision of the International Classification of Diseases (ICD10) of benign myalgic encephalomyelitis as a synonym for postviral fatigue syndrome under Diseases of the Nervous System seems to represent an important moral victory for self-help groups in the UK....The nineteenth century term neurasthenia remains in the Mental and Behavioural Disorders chapter under Other Neurotic Disorders....neurasthenia would readily suffice for ME”. (ref: Chronic fatigue, ME and ICD 10. David A, Wessely S. *Lancet* 1993;342:1247-1248).

*(For a comprehensive (though not complete) review of what Wessely has actually stated in his publications and lectures about those with ME/CFS, see both volumes of Denigration by Design? by Eileen Marshall and Margaret Williams, which provide actual quotations, together with a referenced review of his works during the period 1987-1999, available from (UK) 0208-554-3832 at cost price plus postage).*

Nothing eradicates or changes what has been stated time and again by Wessely about those with ME and CFS; his views are encapsulated in just a few quotations which are included below. These quotations from Wessely’s published works (which number over 200) are included within comments on the final version of the CMO’s report because of their clear significance to it and because of the Government’s apparently consistent refusal to be advised on CFS/ME by anyone other than Simon Wessely and his colleagues.

This begs the question as to whether Wessely (known to have been a Government adviser on ME/CFS in 1992, as confirmed by letter dated 7<sup>th</sup> April from the DLAAB Secretariat) is in fact an approved mouthpiece for the Government’s undeclared but official policy regarding ME/ICD CFS and also towards Gulf War Syndrome. [It is Wessely who heads both the CFS Research Unit and the Gulf War Illness Research Unit at King’s College Hospital, London; both he and Anthony David were funded by the US Pentagon to study Gulf War veterans and he and his colleagues have spent years denouncing the possible existence of any Gulf War Syndrome. Even though 531 UK Gulf Veterans have died and more than 4,000 are still ill over ten years since deployment (ref: *The National Gulf Veterans and Families Association*), Wessely claims no such syndrome exists. In his most recent study of GWS, he states that “Veterans who *believed* they had Gulf war syndrome reported worse health outcomes than those who did not....the strongest factor associated with the belief was knowing another person who held the same belief”. (ref: Prevalence of Gulf war veterans who believe they have Gulf war syndrome: questionnaire study. T Chalder, A David, S Wessely et al *BMJ* 2001, 1<sup>st</sup> September:323:473-476).

Some Gulf War veterans who have attended official events at which Wessely was present are certain that he is afforded protection by plain clothes armed MOD officers: as former serving soldiers, they have no difficulty in recognising an armpit PPK bulge when present].

Certainly it has been demonstrated that ME/ICD CFS can be caused by chemicals: American research has shown that the same anti-viral pathway can be damaged by both viruses and chemicals (*ref*: Interferon-induced proteins are elevated in blood samples of patients with chemically or virally induced chronic fatigue syndrome. Vojdani A, Lapp CW. *Immunopharmacol Immunotoxicol* 1999;21: (2):175-202).

In a Co-Cure posting (Jannarone, 23 September 2001) the author notes the hesitancy of Governments and the chemical / pharmaceutical and medical professions to recognise and acknowledge this; she links the increase in cases of ME/ICD CFS (associated as it is with multiple chemical sensitivity) to chemical exposure and the opening of the blood-brain barrier which together result in enhanced viral activity (which would normally be dealt with relatively quickly if the immune system were not compromised). She discusses the work of Dr. M. Abou-Donia on the synergistic effects of chemicals in the nervous system and notes the rise of chemical use which now affects almost all consumer products; she postulates that the chemical / pharmaceutical industry may have surpassed the ability of the human body to cope with such a chemical onslaught. She mentions that at a recent conference organised by the Chemical Injury Information Network, Abou-Donia pointed out that everyday chemicals break down the blood-brain barrier, allowing more chemicals, viruses and bacteria to invade the brain.

At no time, she believes, will the chemical / pharmaceutical industry or Governments allow such issues to be addressed, because the liability is simply too great.

A link with chemicals and brain function has long been known and this issue is the subject of a meeting to be held at the Royal Society of Medicine on 31 October 2001; it is arranged by the Allergy Research Foundation and is entitled "Allergy and the Brain". It will look at the idea that biologically active chemical compounds in food and the environment may be playing a part in medically unexplained illnesses now known by psychiatrists as "functional somatic syndromes". Speakers include Claudia Miller, Associate Professor of Environmental and Occupational Medicine at the University of Texas, a world expert on multiple chemical sensitivity who with Professor Nicholas Ashford co-authored the book "Chemical Exposure: Low Levels and High Stakes (*van Rostrand Reinhold, New York, 1991; 2<sup>nd</sup> edition 1998*).

A possible link with Wessely and the chemical / pharmaceutical industry is known to exist. Both he and Dr Charles Shepherd (Medical Director of the UK ME Association) are not only members of the CMO's Working Group, but both are members of HealthWatch. This UK organisation, now a charity, is well known for its zealous views which are antagonistic towards alternative and complementary medicine and its practitioners, and towards those who believe in environmental illness and chemical

sensitivity. It is a campaigning organisation which is known to have received funding from the pharmaceutical industry (*ref:* Hansard (Lords):28 April 1993; Hansard (Lords): 10 May 1995). In the campaign's own literature, Wessely is listed as a **“leading member of the campaign”** (*ref:* CAHF (HealthWatch) Subscription form, 1990).

Shepherd has been the subject of recent scrutiny on account of his professional advice to the CMO's Key Group that in cases of CFS/ME, only limited and basic investigations should be carried out; specifically, he advised that no immunological or neuroimaging investigations should be undertaken in the assessment of such patients and this advice is contained in the final version of the report which has been sent to the CMO. This is a matter of concern, as it is precisely such investigations which are delivering evidence of organic pathology in ME/ICD CFS.

On the matter of investigations, the American Medical Association issued a statement, explaining that **90% of CFS/ME patients show normal test results on basic investigations**: Professor Komaroff (Harvard Medical School) said

“Researchers are already using imaging technology to measure brain hormones and are examining the function of the immune system. There is considerable evidence already that the immune system is in a state of chronic activation in many patients with (ME/ICD) CFS”. (*ref:* American Medical Association; Anthony J Komaroff, *Co-Cure 17 July 2001*).

This should be compared with the recommendations of the UK Joint Royal Colleges' Report on CFS, which advises that future research for an “organic” cause is unnecessary:

“ (some people) use the results of immunological tests as evidence for a so-called ‘organic’ component in CFS (but) such abnormalities should not deflect the clinician from the (psychiatric) approach (and) should not focus attention towards a search for an ‘organic’ cause”.

As regards membership of campaigning organisations, if any member of the CMO's Working Group (or any member of any other public body) is a member of any organisation which is known to have been backed by vested interests, then in the interests of transparency such interests should have been declared, but no such potential conflicts of interest are declared in this Government report on CFS/ME.

Within the composition of the CMO's Working Group are those (including Wessely) who have connections with other vested interests groups. Not only is Wessely a member of HealthWatch, he is also connected with PRISMA, a multi-national commercial healthcare company working with insurance companies: PRISMA arranges rehabilitation programmes for those with CFS and its recommended treatment is cognitive behavioural therapy. In the PRISMA Company Information, Wessely is listed as a Corporate Officer: he is a member of the Supervisory Board, which in terms of seniority is above the Board of Management. He is listed as a world expert in the field of “medically unexplained

illnesses”, including Chronic Fatigue Syndrome. The stated aims of PRISMA include identifying “best practices” which they discuss with “leading experts in medical care, the insurance industry and government officials and provide recommendations to healthcare policy makers”. PRISMA claims to be especially concerned with long-term disability from the perspective of governments, service providers and insurance companies. It claims to have developed a “unique treatment programme” for “hopeless” cases (including those with CFS) and it places heavy emphasis on training such “hopeless” cases to regain a “normal life again”. (*ref*: PRISMA Company Information, 2001).

It is a matter of public record that another powerful group with industry connections, the Linbury Trust (a Sainsbury (Supermarket) family trust with approved assets of £12,821,000.00 in 1997-98) is financially supporting the CMO’s report. The Linbury Trust has been funding almost exclusively psychiatric research into “chronic fatigue” since 1991. Those whose work has been supported by this Trust include psychiatrists Simon Wessely (a Reference Group member), Peter White, Anthony Cleare and behaviour therapist Trudie Chalder (all members of the influential Key Group). Anthony Cleare is a Linbury Trust Research Fellow. Other psychiatrists of the Wessely School who have been funded by the Linbury Trust include Anthony David (*see page 5 above*) and Michael Sharpe. In its first “Research Portfolio” on “chronic fatigue”, the Linbury Trust states that one of its primary aims is to ensure that “the Government and its agencies...develop appropriate patient-support mechanisms”, which seems to bear resemblance to the stated aims of PRISMA. (*ref*: Research Portfolio on chronic fatigue, ed. R.Fox; *RSM 1998*).

### **Quotations from Wessely**

Attention is drawn to Wessely’s quotations because they indicate his known stance, and it is Wessely’s stance which underlies both the 1996 Joint Royal Colleges’ Report on CFS and this present report of the Chief Medical Officer.

### **1989**

“Many patients with... chronic fatigue syndrome have embarked on a struggle. This may take the form of trying to find an acceptable diagnosis, or indeed any diagnosis and may involve reading the scientific literature....One of the principal functions of therapy at this stage is to allow the patient to call a halt without loss of face....The patient should be told that ...it is now time to ‘pick up the pieces’ (and) the process is a transfer of responsibility from the doctor to the patient, confirming his or her duty to participate in the process of rehabilitation in collaboration with the doctor. Occasionally patients may say they cannot take drugs....anxiety is often part of the syndrome (and) sexual problems occur in the majority of patients referred to hospital. The notion of allergies...reinforce the view that the sufferer is under attack from outside elements which have nothing to do with himself or herself”.

(*ref*: Management of chronic (postviral) fatigue syndrome. Simon Wessely, Anthony David, Sue Butler, Trudie Chalder. *JNNP January 1989:26-29*).



**1990**

“Our results are close to those predicted by... ‘learned helplessness’ (and) inappropriate referrals to physicians can lead to extensive physical investigation that may perpetuate the symptom pattern of physical attribution”  
(*ref: Attributions and Self-Esteem in Depression and Chronic Fatigue Syndrome. R Powell, R Dolan, S Wessely. J Psychosom Res 1990:34:6:665-673*).

“It is assumed that ME is an organic disorder of the peripheral or central nervous system. In the initial reports this was indicated by frank neurological signs (but) the concept of ME has shifted...as in neurasthenia, the emphasis is on muscle fatiguability...in a current leading neurology text book (Adams and Victor, 1985) chronic fatigue, neurasthenia and depression are seen as synonymous. Mood disorder is found in many cases of ME but it is not the only psychiatric disorder (and) some patients do satisfy the criteria for anxiety and phobic disorders...Beard’s neurasthenia began as a physical disease...it provided the most respectable label for distressing, but not life-threatening complaints, one that conferred many of the benefits - and fewest of the liabilities- associated with illness...it was preferable to the alternatives --- hypochondria, malingering and insanity. There is little evidence of any change in the current era. Suggestible patients with a tendency to somatize will continue to be found among sufferers from diseases with ill-defined symptomatology until doctors learn to deal with them more effectively. The social processes that govern the creation of such illnesses remain obscure but one may argue that they represent culturally sanctioned expressions of distress. It has been shown that some patients have always preferred to receive, and well-meaning doctors to give, a physical rather than a psychological explanation for ill-defined illnesses associated with fatigue. Such uncritical diagnoses may reinforce maladaptive behaviour”.(*ref: Old wine in new bottles: neurasthenia and ME. Simon Wessely. Psychological Medicine 1990:20:35-53*).

“A number of patients diagnosed as having...myalgic encephalomyelitis were examined.....in many of them, the usual findings of simulated weakness were present... (the epidemic of ME) may have resulted from ...altered medical perception.....Over-espousal of new illness can be harmful...it may legitimize some of the maladaptive behaviour already described. (*ref: The chronic fatigue syndrome --- myalgic encephalomyelitis or postviral fatigue. Wessely S, Thomas PK. In: Recent Advances in Clinical Neurology No 6. ed: C Kennard. Churchill Livingstone 1990:85-132*).

Also in 1990, Wessely published his now-notorious view about ME patients:

“ The description given by a leading gastro-enterologist at the Mayo Clinic remains accurate: ‘the average doctor will see they are neurotic and he will be disgusted with them’. It is (my) belief that the interaction of the attributional behaviour factors is responsible for both the initial presentation to a physician and for the poor prognosis”

(ref:: Chronic fatigue and myalgia syndromes. Wessely S. *In: Psychological Disorders in General Medical Settings. ed: N Sartorius et al. Hogrefe & Huber 1990).*

## **1992**

“Validation is needed from the doctor....once that is granted, the patient may assume the privileges of the sick role (sympathy, time off work, benefits etc”. (ref:: Chronic fatigue syndrome: current issues. Wessely S. *Reviews in Medical Microbiology 1992:3:211-216).*

In 1992, on 10<sup>th</sup> January Wessely wrote a letter to Dr Mansel Aylward at the Department of Social Security in which he stated

“It is certainly true that I and my colleagues consider that anxiety about the consequences of activity is one of the factors perpetuating disability in CFS.... I have previously been involved in advising the DSS that CFS should not be grounds for permanent disability”.

(Following Wessely’s advice, the 1994 Disability Living Allowance Handbook entry on CFS states “The general consensus of informed medical opinion...is that treatment should be by graded exercise and rehabilitation (and) antidepressant drugs may be helpful”).

## **1993**

“Inherent in the concept of allergy is the avoidance of any blame. Sufferers from allergies feel no guilt about their condition and are not subject to moral sanction”. (ref: The psychology of multiple allergy. LM Howard, S Wessely. *BMJ 1993:307:747-748).*

## **1994**

“ Most doctors in hospital practice will be familiar with patients who complain ...about a wide variety of symptoms but whose physical examination and investigations show no abnormality...(Such) symptoms have no anatomical or physiological basis..... Patients at the severe end of the spectrum exert a disproportionately large and avoidable financial burden on the health and social services....Patients with inexplicable physical symptoms are usually strongly resistant to any psychological interpretation (and) are generally viewed as an unavoidable, untreatable and unattractive burden”. (ref: Patients with medically unexplained symptoms. Alcuin Wilkie, Simon Wessely. *British Journal of Hospital Medicine, 1994:51:8:421-427)*

Multiple allergy and chemical sensitivity are extensively documented in the medical literature as being a well-recognised component of ME/ICD CFS, so the following quotation is especially relevant:

### 1995

“Many doctors...are frequently consulted by patients with persistent unexplained symptoms attributed to allergy or chemical sensitivity...when patients are told there is no evidence of any underlying immunological or allergic cause, they can be difficult to manage...In some cases patients claim allergy to almost all of the environmental products of the Western world...The illness is usually sporadic but epidemics have been described. Such epidemics overlap with the related subject of mass psychogenic illness, a term which has partly replaced mass hysteria. The epidemiology of environmental illness..is reminiscent of the difficulties encountered in distinguishing between the epidemiology of myalgic encephalomyelitis (ME), a belief, and chronic fatigue syndrome, an operationally-defined syndrome. (*The World Health Organisation does not regard ME as “ a belief”, but as a neurological disorder*). These patient populations recruited from the environmental subculture...are a subgroup of patients who can be expected to show unusually strong beliefs about the nature of their symptoms, associated with a high prevalence of psychiatric disorder. These patients typically resist any attempt to discuss the possibility of a psychological cause. Somatization sufferers...consume vast amounts of health resources for little benefit...Between a quarter and a half of new patients attending medical clinics do not have an...organic explanation for their symptoms, (receiving) a diagnosis of...chronic fatigue syndrome....The risk of psychiatric diagnosis is known to increase linearly with the number of symptoms with which the patient presents.....Attribution of unexplained symptoms to a “virus”, as happens in most patients with the label of ME, may preserve self-esteem and protect against the stigma of psychiatric disorder. These total allergy syndromes are akin to culture-bound syndromes afflicting modern developed societies where sufferers from unexplained symptoms no longer see themselves as possessed by devils or spirits but instead by gases, toxins and viruses.....When a psychiatric disorder is not recognised, patients are often investigated extensively for organic disease; there are hazards in these inappropriate investigations, as patients’ beliefs in organic pathology are reinforced. Further investigations will add nothing to the management but will reinforce the patient’s beliefs in organic pathology (and) add to the cost of the consultation. Patients will benefit from training in cognitive coping skills; (and some) patients should be treated with psychotropic drugs.... Liaison between the physician and the liaison psychiatrist is necessary so that patient acceptance of psychiatric referrals can be facilitated”. (*ref: Psychiatry in the allergy clinic: the nature and management of patients with non-allergic symptoms. LM Howard, S Wessely. Clinical and Experimental Allergy 1995:25:503-514*).

**1996**

“Chronic fatigue may be better understood ...by focusing on perpetuating factors and the way in which they interact in self-perpetuating, vicious circles of fatigue, behaviour, beliefs and disability....The perpetuating factors include inactivity, illness beliefs and fear about symptoms, symptom focusing, and emotional state....CFS is dogged by unhelpful and inaccurate illness beliefs, reinforced by much ill-informed media coverage...they include fears and beliefs that CFS is caused by a persistent virus infection or immune disorder....Increased symptom focusing occurs in CFS sufferers; (this) increased concern leads to selective attention and ‘body watching’: this can intensify the perceived frequency of symptoms, thereby confirming illness beliefs and reinforcing illness behaviour. There lies at the heart of CFS not a virus, immune disorder or depression, but a distortion of the doctor-patient relationship”. (ref: Chronic fatigue syndrome: an update. Anthony J Cleare, Simon C Wessely. *Update 1996:14 August:61*).

**1997**

“The majority of patients seen in specialist clinics typically believe that their symptoms are the result of an organic disease process, and resent any suggestion that they are psychological in origin or psychiatric in nature. Many doctors believe the converse. (Patients’) beliefs are probable illness-maintaining factors and targets for therapeutic intervention....Many patients receive financial benefits and payment which may be contingent upon their remaining unwell. Gradual recovery may therefore pose a threat of financial loss.....Abnormal physical signs should not be accepted as compatible with a diagnosis of CFS. The only treatment strategies of proven efficacy are cognitive behavioural ones. We have developed a more intensive (CBT) therapy (which) is acceptable to patients, safe, and more effective than either standard medical care or relaxation therapy. It has also been shown to be cost-effective. An important task of treatment is to return responsibility to the patient for management and rehabilitation without inducing a sense of guilt, blame or culpability for his / her predicament”. (ref: Chronic fatigue syndrome: a practical guide to assessment and management. Sharpe M, Chalder T, Wessely S et al *General Hospital Psychiatry 1997:19:3:185-199*).

**1998**

“...CFS may be better understood as the extreme end of a spectrum that starts with ‘feeling tired all the time’. Many people suggest that the condition should be called ME, but doctors and the editors of journals have taken a firm stand against this label.. The GP’s response may be important. A sick note and unclear diagnosis are both associated with development of CFS”. (ref: Clinics in Controversy: Chronic Fatigue Syndrome. Anthony J Cleare Simon C Wessely. *Update 20 May 1998:1016-1026*).

**1999**

“ We postulate that the existence of specific somatic syndromes is largely an artefact of medical specialisation. That is to say that the differentiation of specific functional (ie. psychiatric) syndromes reflects the tendency of specialists to focus on only those symptoms pertinent to their speciality, rather than any real differences between patients... Various names have been given to medically unexplained symptoms. These include somatisation, somatoform disorders...and functional somatic symptoms...we define a functional somatic symptom as one that, after appropriate medical assessment, cannot be explained in terms of a conventionally defined disease. Functional somatic syndromes pose a major challenge to medicine. Those symptoms...are associated with...unnecessary expenditure of medical resources. Chronic fatigue syndrome is associated with worse disability than conditions such as heart failure...three quarters of patients had symptoms more than 10 years after presentation. Thus, functional somatic complaints constitute a large...and costly health-care issue that urgently requires improved management. Many of these (functional somatic) syndromes are dignified by their own formal case definition and body of research...we question this orthodoxy and ask whether these syndromes represent specific diagnostic entities (eg. irritable bowel syndrome, premenstrual syndrome, fibromyalgia, hyperventilation syndrome, tension headaches, globus hystericus, multiple chemical sensitivity, chronic fatigue syndrome) or are rather more like the elephant to the blind man --- simply different parts of a larger animal?...Such patients may have variants of a general functional somatic syndrome. If we accept that functional somatic syndromes are considered together, we open the way for more general strategies for their management....Functional somatic symptoms and syndromes are a major health issue. They are common, and may be costly. Most of the current literature pertains to specific syndromes...we have put forward the hypothesis that the acceptance of distinct syndromes as defined in the medical literature should be challenged. We contend that the patients so identified...have much in common...We propose an end to the belief that each different syndrome requires its own particular sub specialist...A previous generation of physicians noted overlaps between “psychosomatic syndromes”....Unfortunately, none of these theories were accompanied by empirical support and consequently have disappeared from our current thinking...We argue that their re-instatement is overdue”. (ref: S Wessely, C Nimnuan, M Sharpe. *Lancet* 1999:354:036-939).

Wessely's determination to eradicate ME as a legitimate medical entity seems never to cease. His recent and most blatant attempt formally to re-classify ME as a mental / behavioural disorder can be found in his contribution to the WHO Guide to Mental Health in Primary Care (November 2000). He notoriously re-classified ME without the customary prior approval of the WHO, although by the use of the WHO logo on his website, the implication was that Wessely's contribution did carry WHO sanction. Wessely's actions brought forth international condemnation and the WHO has admitted that it was done without its sanction (*see the international correspondence on this matter which has been posted on the Co-Cure internet list*).

Wessely is at last being publicly challenged, but not from within the UK: in a letter dated 5<sup>th</sup> September 2001 to the Director General of the World Health Organisation in Geneva (Dr Gro Harlem Brundtland), the Chief Executive of CFIDS Association of America made it plain that Wessely's actions were insupportable, writing

“The diagnostic criteria in the (WHO Guide to Mental Health in Primary Care) are not consistent with the internationally accepted published criteria....Rather they reflect relatively loose criteria used only by a small number of researchers and clinicians in the UK. It is surprising that the ..international criteria would not be provided, given that Dr Simon Wessely, an author of the CFS section in the WHO Guide, is also an author on the 1994 international definition. CFS is not considered by leading researchers of the illness to be a mental disorder, as indicated by the WHO Guide. Numerous biological abnormalities of the immune, endocrine and circulatory systems have been documented (which) are not referenced in the WHO Guide (by Wessely). Risk and perpetuating factors (such as claimed by Wessely) have never been proven to be associated with CFS/ME, therefore the WHO Guide contains misleading information when it states that lifestyle factors are responsible for the development of CFS/ME.....the information in the WHO Guide to Mental Disorders in Primary Care is inaccurate, incomplete and inconsistent with WHO's own guidance in ICD-10 (and) the CFIDS Association of America calls for the immediate removal of this section....”.

By comparison, the two major UK patients' charities were curiously reticent about any representations to Geneva which they may have made on this critical issue and have declined legitimate requests to make their position clear.

Following representations by others, a statement was issued on 17 September 2001 by Andre' l'Hours, Technical Officer at the WHO in Geneva, which specified that **“there is now a clear distinction between chronic fatigue, fatigue syndromes and neurasthenia on the one hand and chronic fatigue syndrome and ME on the other”**.

### Potential explanations for Wessely's stance

It may be salutary to consider whether there could be any undisclosed connection between Wessely's obsession with re-classifying ME as a psychiatric disorder and two major but under-reported changes which are taking place, namely the Strasbourg Convention and the Reform of the UK Mental Health Act (1983).

The Strasbourg Convention (*ref: Conseil d'Europe Convention for the Protection of Human Rights and Dignity of the Human being with Regard to the Application of Biology and Medicine: Convention of Human Rights and Biomedicine. DIR/JUR/Directorate of Legal Affairs. Strasbourg, November 1996*)

On 19<sup>th</sup> November 1996 the UK signed the preliminary draft of the Council of Europe Strasbourg Convention on Human Rights and Biomedicine, and it is apparently scheduled to be ratified within the term of this present government. The Convention confers certain rights on member states who sign the final document; those conferred rights include provision for drug and other medical trials on human beings which, in certain circumstances, could be carried out without the individual's consent. For three groups of people in particular, such consent will not always be needed in future:

- (i) those who are deemed to be mentally ill
- (ii) those for whom no other known treatment is effective
- (iii) children

Specifically, "general interests" may take precedence over those of the individual.

This would appear to pave the way for sweeping relaxation of informed consent to medical treatment and to annul the fundamental human rights which were enshrined in the Code of Medical Ethics drawn up in 1948 after the atrocities committed by the Nazis in World War II specifically so that no-one would ever again be forced to participate in an experimental trial.

Simultaneously to the European Strasbourg Convention, the United States government decided that in future, individuals can be enrolled in medical research programmes without their consent; new Food and Drug Administration (FDA) rules now allow the use of experimental treatment in certain situations which are similar to those set out in the Strasbourg Convention. (*ref: FDA no longer requires consent for medical research. The Mouse Monitor, January 1997, page 27*).

### Reform of the UK Mental Health Act (1983)

Proposals for the reform of the Mental Health Act were drawn so widely that they would give psychiatrists far greater powers to enforce compulsory psychiatric treatment upon both adults and children. Proposals include the provision for psychiatrists to be able to drug people (including children against the wishes of their parents) if they have **"any disability or disorder of the mind or brain, whether permanent or temporary, which**

**results in an impairment of mental functioning”**. (ref: Mind control drug threat for children. Anthony Browne, Health Editor, *The Observer*, 27<sup>th</sup> February 2000).

When representations as to what impact, if any, these changes might have on those with ME/ICD CFS were made to the Government, a letter from the Minister of State at the Department of Health (dated 4<sup>th</sup> May 2000 and signed by John Hutton) was less than reassuring, as it seemed not to rule out the eventual re-classification of ME as a mental disorder:

“ it is highly unlikely that (CFS/ME) sufferers would qualify for detention under the Act - **even if it were reclassified as a mental rather than a physical disorder**”.

It is entirely possible that those with CFS/ME would come within the framework of the Strasbourg Convention if not within the reforms of the UK Mental Health Act if the Wessely School of psychiatrists eventually manages to succeed in getting all conditions with “medically unexplained symptoms” re-classified as “psychiatric”. In the light of the heavy emphasis on psychiatric problems by this particular group of psychiatrists and its adherents, such a possibility cannot be discounted.

It seems likely that these two momentous changes indicate the intended direction of government policy. Is a mere coincidence that on 7<sup>th</sup> June 2000 the Deputy Chair of the CMO’s Working Group on CFS/ME (Professor Pinching) is on record as stating that there is no need for research into CFS/ME?

However improbable one might wish it to be, there may even be another aspect to the apparent willingness of the Government to accept a “psychiatric” classification of disorders such as Gulf War Syndrome, ME/ICD CFS and multiple chemical sensitivity. There is extensive documentation (particularly in the archives of the Sabin Institute) about the development by the US and UK Governments during World War II of viruses which cause viral encephalopathies. In the 1980s, some were shipped to Saddam Hussein in Iraq. This is extensively documented in the 1994 Riegle Report to the US Congress (ref: US Chemical and Biological Warfare Related Dual Use Exports to Iraq and their Possible Impact on the Health Consequences of the Gulf War – A Report of the Chairman Donald W Riegle Jr. *United States Senate, 103<sup>rd</sup> Congress, 2<sup>nd</sup> Hearing, May 25<sup>th</sup> 1994*). Three New York Times journalists have co-authored a book on this biowarfare (ref: *Germs: Biological Weapons and America’s Secret War*. Judith Miller, Stephen Engelberg and William Broad. *pub Simon and Schuster, 2001*). It is a very chilling read.

For whatever reason, the fact that Wessely et al are not studying patients with ME/ ICD CFS (ie. those with neuroimmunological illness) but those with psychiatric disorder has been noted in the international literature by many, including Professor Friedberg from the State University of New York (ref: *A Subgroup Analysis of Cognitive Behavioural Treatment Studies*. Fred Friedberg. *JCFS 1999;5:3-4:149-159*).



**It is beyond comprehension that a UK Government report should fail to make this clear and should once again allow Wessely's influence to perpetuate such mis-information in the CMO's report, unless in reality Wessely is acting on behalf of and with the approval of the Government.**

page 11 para 1.4.3 (Prognosis)

The report states *“The likelihood is that most patients will show some degree of improvement over time, especially with treatment”*. This sentence is repeated in different sections throughout the report. No references are supplied in support of such an assertion and even though the following paragraph acknowledges that prognosis is *“extremely variable”*, such a statement in a Government report is misleading. Much depends on which form of “CFS” is being considered. There is absolutely no evidence that such an assertion applies to those with severe ME, most of whom are far too ill to get to a tertiary referral centre or to take part in any trial (which the report itself later acknowledges) and so cannot be the reason for *“selection bias in studies towards inclusion of those with poorer prognosis”*.

## **Chapter 2 (Patient evidence)**

Overall, chapter 2 is very good, but from the perspective of Government policy (which is what counts) it is nothing more than a recital of “the patients’ experience” and what patients themselves wish to see happen. The report records this experience but does not signify Government acceptance of it: the editorial team is at pains to point out that the recommendations are “patients’ suggestions” which is very different from being the recommendations of the report itself.

Of particular concern is that (as in chapter 1) **there is no acknowledgment of the organic pathoetiology of the disorder: interpretation of what is written is left entirely to the reader, so those who wish to believe that ME/CFS is a psychiatric illness can still do so.** People suffering from some psychiatric illness can be severely affected physically, so it is important to specify that ME/ICD CFS is a **physical illness with biomarkers of organic pathoetiology:** once again this is not addressed and it is a serious omission as well as a lost opportunity to educate both healthcare professionals and the general public (listed as a specific recommendation in chapter 6 of the report).

## **Chapter 3 (Nature & Impact of CFS/ME)**

This chapter deals with two aspects: (i) the nature and (ii) the impact of the disorder; the section dealing with the impact is mostly very good, but there are serious problems with some of the content of the section on the nature of the disorder, all of which have been previously addressed (with references), with those concerns having several times

been submitted to the Key Group. At the beginning of this chapter, the report states “research is increasingly providing important clues, notably on factors that predispose, precipitate or perpetuate the condition”: to experienced clinicians such phrases immediately convey that the disorder is considered to be non-organic in nature. The chapter continues “ we examine the nature..of the condition with the following aims: To support a more consistent approach to prompt clinical recognition and appropriate management”. There is no suggestion that the best approach to prompt recognition of the disorder is to use the “evidence-based” technique of clinical laboratory investigation : only psychological approaches are accorded the status of being “evidence-based”.

Particular areas of concern about this chapter are as follows:

page 29: “it is not clear whether the disease is more common now than previously” This is inaccurate, as it is known that the incidence of ME/ICD CFS is rising and written evidence of this was submitted to the Key Group. There is statistical evidence from UNUM, one of the largest disability insurers who as long ago as April 1994 reported that from the five years 1989-1993, men’s disability claims for CFS increased by 360% whilst women’s claims for CFS increased by 557%. **No other disease category surpassed those rates of increase. In order of insurance costs, CFS/ME came second in the list of the five most expensive chronic conditions, being three places above AIDS.**

A recent article in *The Guardian* states “There is an illness abroad in the UK that is now affecting hundreds of thousands of people (which) is on the increase” (ref: A very modern epidemic. Sarah Bosely. *Guardian*, 27<sup>th</sup> September 2001). If reputable journalists know that the disorder is on the increase, why do advisers to the CMO appear not know this?

page 30: “ “Encephalomyelitis”...is incorrect because the term implies a pathophysiological process for which no evidence exists” There is evidence of CNS inflammation (at least in a subset), and references from 1977 to date were supplied for the use of the Key Group and the NHS Executive. The report completely ignores the seminal work of Buchwald, Cheney, Komaroff and Gallo et al (*Ann Int Med* 1992: 116:103-113), which states “ **Neurologic symptoms, MRI findings and lymphocyte phenotyping studies suggest that the patients may have been experiencing a chronic, immunologically mediated inflammatory process of the central nervous system**”.

page 31: “there is good quality evidence that some factors trigger CFS/ME, while others maintain it”. The report lists “personality” and “mood disorder” as triggering factors but there is not a shred of evidence to support this in ME/ICD CFS; it lists “mood disorders”, “inactivity” and “illness beliefs” as maintaining factors, but there is no evidence that this applies in cases of ME/ICD CFS and the report provides no supportive references.

page 33 / 34: Under “Possible disease mechanisms”, the “Biopsychosocial model” is top of the list of possible mechanisms for the disorder. There is absolutely no evidence that a “biopsychosocial model” is a possible disease mechanism in cases of ME/ICD CFS

(though this may be so for Wessely-defined “CFS”). A biopsychosocial model argues that once an illness has started, its expression is affected by beliefs, coping styles and behaviour. If the CMO’s report insists on making no distinction between the two interpretations of “CFS”, then by implication it is condoning mis-information and this could have a significant and detrimental impact on ME sufferers and on management outcomes. This model is no longer credible in the light of all the biomarkers of organic pathoaetiology which are now well-documented in the literature.

As confirmed by Professor Leonard Jason from De Paul University, Chicago, ME/ICD CFS can affect virtually every major system in the body: a considerable challenge facing CFS research is the issue of patient heterogeneity, as a result of which some studies are, at best, discrepant and at worst, contradictory. This uncontrolled heterogeneity is one consequence of ignoring the important issue of sub-classification. As Jason states, for years investigators have noted many biological abnormalities in ME/ICD CFS patients, including an over-activated immune system, biochemical dysregulation in the 2-5A synthetase/RNase L pathway, cardiac dysfunction, EEG abnormalities, abnormalities in cerebral white matter, decreases in blood flow in certain areas of the brain (see below) and autonomic dysfunction (*ref: Subtypes of Chronic Fatigue Syndrome: A Review of Findings. Leonard A Jason et al. JCFS 2001:8: 3-4:1-21*). **Such abnormalities cannot be psychosocial in origin.**

Signs such as Rombergism, nystagmus and neuromuscular inco-ordination, and symptoms of vertigo, vasculitis (with convincing laboratory evidence of an abnormality in cholinergic activity within the vascular endothelium, with disruption of microvascular integrity), and findings of pancreatic, adrenal and thyroid dysfunction (including low free T3), an enlarged liver with disruption of liver enzymes, together with convincing laboratory evidence of delayed muscle recovery after fatiguing exercise, plus evidence of brain stem impairment **cannot possibly be the consequences of beliefs**, any more than can measurable orthostatic hypotension, hair loss, mouth ulcers, and increased CD4-CD8 ratio, inverted T waves on Holter monitoring and reduced lung function tests, all of which are clearly documented in the non-psychiatric ME/ICD CFS literature. For the CMO’s report to include the “biopsychosocial” model of the disorder as a possible disease mechanism (and to give this model precedence by placing at the top of the list) entirely defies credibility.

page 34: *“Immunological abnormalities...their relationship to the illness has not been established”*. This is disingenuous and misleading. Immunological abnormalities have been consistently documented in the medical literature since 1987. In 1991, Professors Buchwald and Komaroff stated **“the abnormalities we find most impressive are those involving the immune system. There is evidence of diffuse immunologic dysfunction.** (*ref: Review of Laboratory Findings for Patients with Chronic Fatigue Syndrome. Dedra Buchwald and Anthony L Komaroff. Rev Inf Dis 1991:13: (Suppl 1):S12-S18*). In 1995, the same authors (and others) stated **“The immunological abnormalities are in accordance with a growing body of evidence suggesting chronic, low-level activation of the immune system in chronic fatigue syndrome. We conclude that objective laboratory test results distinguish a group of patients with CFS from a group of**

**healthy control subjects. This observation suggests the presence of a biological process that...may be responsible for the symptoms of CFS”** (*ref: Clinical Laboratory Test Findings in Patients with Chronic Fatigue Syndrome. David W Bates, Dedra Buchwald, Anthony L Komaroff et al. Arch Intern Med 1995:155:97-103*).

It has long been accepted by the most eminent experts that the spectrum of disorders which are immunologically mediated must now include ME/ICD CFS (*see the immense body of immunological references in the literature, especially A study of the immunology of the chronic fatigue syndrome: correlation of immunological parameters to health dysfunction. IS Hassan, W Weir et al. Clin Immunol Immunopathol 1998 and Review: Immunology of Chronic Fatigue Syndrome R Patarca, N Klimas et al JCFS 2000:6:3-4:69-107, which contains 212 references*).

page 36: “Symptoms such as postural hypotension and dizziness can in part reflect the secondary effects of inactivity...” Patients with ME suffer orthostatic (not postural) hypotension and orthostatic hypotension is a well-recognised hallmark of neurovascular disease. There is no evidence of postural hypotension in ME. Such a statement in a report of the UK CMO indicates editorial carelessness.

#### **Chapter 4 (Management of CFS/ME)**

This chapter on management bears no relationship to the disorder described in the patients’ experience in the current chapter 2 and in the section dealing with “Impact” in the current chapter 3. It is nothing more than the promotion of cognitive behavioural therapy and is entirely inappropriate for those suffering from ME / non-Wessely School “CFS”: it makes no mention of the many biomarkers presented at the Fifth International AACFS Research and Clinical Conference held in Seattle in January 2001 which underpin the organic pathoaetiology and it entirely fails to distinguish between the Wessely et al interpretation of CFS and the ICD interpretation of CFS (which equates with ME).

This chapter purports to rely upon “evidence-based medicine” despite acknowledgment (by the team which reviewed the literature) of the paucity of good quality evidence to support the recommended management strategies.

It claims to be based upon a “systematic review” of the literature on “management” of the disorder commissioned by the Policy Research Programme Division of Department of Health which was carried out by a team at the Centre for Reviews and Dissemination at the University of York. This systematic review was largely based on papers from Wessely’s own personal database, a fact confirmed by the CMO himself in a letter sent in September 1999 (it omitted the exact date). Moreover, it was Wessely himself, Professor Pinching and Chris Clark, Chief Executive, Action for ME who were “expert advisers” to the team which carried out the systematic review. That Clark (newly in post at the time and on his own admission totally inexperienced in the field) was deemed to have enough

working knowledge of either ME or the medical literature to act as “adviser” to the review team was the subject of written representation to the NHS Executive, who by letter dated 7<sup>th</sup> July 2000 replied “*we wish to make no comment regarding Chris Clark’s knowledge or experience of cfs/me*”. That letter also stated “*The expert panel were carefully chosen to provide a balanced and representative group*”. This has been disputed by patients’ representatives.

The influence of the expert panel of advisers to the systematic review team may be deduced from the acknowledgment accorded by the authors of the review: “*We would also like to thank the advisory panels to the reviews for their help during the various stages, including commenting on the protocols and draft reports*”. (ref: Interventions for the Treatment and Management of Chronic Fatigue Syndrome: A Systematic Review. Penny Whiting et al. *JAMA* 2001;286:1360-1368). Such public acknowledgment of input by the advisory panel (which included Wessely) to the systematic review seems not to accord with his claim that “I am not an influential member.... I have never been to a meeting” (*correspondence of 6<sup>th</sup> July 2001*).

Despite the fact that much emphasis is currently placed on the value of “evidence-based medicine”, one medical commentator on the book “Clinical Evidence” (published by the BMJ) noted “The striking observation from this book is that the benefits of almost any medical treatment are marginal”. (ref: COMMENT: Don’t blame the surgeons, it’s our approach to health that is at fault. Robert Baker. *Independent* 19 July 2001).

The movement to incorporate “evidence-based” medicine into clinical practice has acted to the detriment of those with ME/ICD CFS and other “medically unexplained” syndromes: one of the underlying problems in current medicine which relates particularly keenly to ME/ICD CFS patients is that modern medicine does not listen to patients any more, nor does it pay much attention to their symptoms; instead, it respects only laboratory results. The foundations upon which medicine was based for centuries are increasingly ignored in favour of exclusive reliance on laboratory results (which are deemed to be “evidence”), with doctors now preferring to rely on such “evidence” instead of using old-fashioned skills of clinical judgment, observation and experience. According to a posting from Jed Gallagher on Co-Cure on 21 September 2001, Dr Gordon RB Skinner explained the problem in a nutshell, namely: “*..a current misconception that evidence-based medicine means laboratory-based medicine. Clinical observation, albeit of an objective nature...is accorded lower evidential weight than laboratory measurements. This represents an example of a...general misconception in medical science*”. This prevailing misconception certainly applies in ME/ICD CFS.

In her book “Under the Medical Gaze: Facts and Fiction of Chronic Pain (University of California Press, 2001), Susan Greenhalgh, Professor of Anthropology at the University of California (Irvine) and herself a sufferer from a “medically unexplained syndrome” adduces that patients are deeply affected by the uncertainty surrounding the management of such conditions, and that this has to do with “*the workings of power and culture in the biomedical domain*”. Again, that certainly seems to apply in ME/ICD CFS.

CBT does not work in at least two-thirds of cases of CFS/ME and evidence of this was sent directly to the CMO on 10 April 2001 by the Countess of Mar in her capacity as Patron of the 25% ME Group for the Severely Affected; by letter dated 6<sup>th</sup> June 2001 the CMO replied in the following terms: “*I have read the letters and attachments myself....you make some very important points in your submission, which I will take up with the Committee*”. (The submissions to which the CMO refers are comments submitted on behalf of the 25%ME Group for the Severely Affected on the chapters dealing with diagnosis and management in earlier drafts of the report).

The CMO’s promise notwithstanding, almost nothing has changed from the previous drafts in the chapter advocating CBT and GE as the best management for CFS/ME.

This is so despite the fact that the final version of the CMO’s report itself records in Online Annexe 3 that 50% of 1214 respondents were made worse by graded exercise and that 67% of 285 respondents found that CBT made no change at all, whilst 26% were made actively worse. It also concedes that the effects of CBT and GE on the severely affected are unknown.

**On what rational basis therefore can the CMO accept the report’s recommendations that CBT and GE are the “evidence-based” treatment of choice for ME/ICD CFS?**

By comparison, the United States Centres for Disease Control CFS Programme Update, 29 August 2001 confirms that the CDC is looking at gene expression, neuroendocrine, immune function and at pathogen discovery in CFS/ME, together with laboratory testing of autonomic nervous system function and cytokine profiles: studies of gene expression in CFS/ME have yielded intriguing results which indicate that sufferers’ gene expression is distinct from that of controls, and that differential gene expression can point to altered metabolism pathways.

In this respect, attention must be drawn to evidence which was presented at the Fifth AACFS International Research and Clinical Conference held in Seattle in January 2001. A study was conducted to determine the presence or absence of RNA in ME/ICD CFS patients: all chronic illnesses studied (including Gulf War Syndrome, ME/ICD CFS, AIDS and multiple myeloma) **show prominent RNA not observed in normal controls. Prominent RNA bands so far sequenced show homology with human genes which are noted for their tendency for gene rearrangement under severe physiologic stress.** The most amplified sequences appear to be disease specific. (*ref: RNAs in the plasma of patients with chronic fatigue syndrome: a novel mechanism for chronic illness expression with both treatment and diagnostic implications. RP Cheney, HB Urnovitz. AACFS Conference #074, January 2001*).

Dr N Afari, Assistant Director of the University of Washington CFS Research Centre, said at the Conference that genetic abnormalities may team up with environmental influences to produce ME/ICD CFS and that environmental influences which worldwide

researchers are investigating include the frequent pairing of ME/ICD CFS with food and chemical sensitivities.

The CDC CFS programme is also looking at a novel retrovirus (the JHK virus) recently isolated by Grossman from a human B-lymphoblastoid cell line: immunoelectron microscopy has demonstrated that sera from a subset of CFS/ME patients binds to the JHK virus particle. (“JHK” stands for the initials of the first patient from whom the virus was isolated).

A further arm of the CDC CFS programme is looking at the characterisation of autoantibodies in CFS/ME --- various infectious agents have been incriminated in the pathogenesis of autoimmune disease, and because CFS/ME has many characteristics of autoimmune disease, the CDC has commissioned the Scripps Institute at La Jolla, California (the world leader in immunology) to determine the presence or absence of 15 common and recently described autoantibodies in CFS/ME.

According to the CDC statistics, **only 4% of CFS/ME patients had full remission at 24 months**, and the CDC states that its major emphasis is to legitimise CFS/ME to healthcare providers and to state health officials and insurance companies: the CDC describes CFS/ME as “A diagnostic and management challenge”.

In the UK, however, clinicians are to be informed that CFS/ME is perpetuated by “illness beliefs” and “personality” which are amenable to a “management plan” administered by a “multidisciplinary team” including psychotherapists.

The chapter on management seems to have been written in isolation from the now-substantial base of scientific knowledge of CFS/ME as accepted by the rest of the world and it should not be allowed to go unchallenged by the UK medical and scientific community. On past experience, however, such challenges may not get past the referees.

#### Specific criticisms re chapter 4 / Clinical Management

page 43: *“improvement is possible with treatment in the majority of people”*. Once again this sentence appears. There is no evidence to support such a statement; on the contrary, it is at variance with the known facts. Dr Abhijit Chaudhuri, Senior Clinical Lecturer in Neurology at the University of Glasgow (where thousands of CFS/ME patients are believed to have been seen) is on record as stating that **80% of patients do not get better**. At his presentation to the Scottish Parliament on 4<sup>th</sup> April 2001, Chaudhuri informed MSPs that **there is a low rate of recovery**. He also advised MSPs that the condition is not due to somatisation in correctly diagnosed patients, yet the only “treatment” on offer in the CMO’s report is psychotherapy which is designed to amend a patient’s thinking patterns, and the report acknowledges that *“we found insufficient evidence available to guide specific management of those people who are severely affected”*. Thus no treatment is available for the severely affected who are bed/house bound and who (as the final version itself acknowledges) are too ill to attend hospital or

even a GPs surgery. The report offers no suggestions at all for such patients, merely that it is not necessary for them to be fully investigated.

page 44: “*CFS/ME is a genuine condition*”. Again, there is no mention that ME is classified as a neurological disorder in the ICD, nor is there any mention that CFS/ME is not a psychiatric disorder, so once again, interpretation and acceptance of the disorder is left to the reader’s own judgment, with consequent implications for acceptance by those who do not have the benefit of knowing the world literature apart from that of the Wessely School. It is the Wessely School literature which has flooded the UK literature for many years to the virtual exclusion of non-psychiatric studies, whose authors have great difficulty in getting their papers into UK mainstream medical journals for which Wessely and his colleagues act as referees on matters relating to this disorder. This may explain why the systematic review of the literature came to conclusions which were anticipated by those who know that literature.

It is not until page 44 that the report acknowledges “*a divergence of views on general models of disease*” but it fails to mention the available published evidence which supports an organic pathoetiology, concentrating instead on the psychiatric aspects.

page 45: the Working Group agreed that they “*would identify approaches to management for which there is evidence of clinical effectiveness*” and would “*develop as annexes to this report, resource tools to guide diagnosis and clinical management (Annexes 6 and 7)*” but the reality is that there is **no** management approach for which there is convincing evidence of clinical effectiveness, so the report should acknowledge this instead of making inflated claims for psychotherapy (which works for only one third of those who are well enough to access it). Uninformed clinicians (ie. the majority) will rely on the Online annexes and will assume that the recommended management strategies are based on solid evidence, so their existing prejudices will be confirmed and enhanced.

page 46: “*All clinical interventions carry a potential risk of harm, especially if applied incorrectly; for CFS/ME in particular, imposed, rigid programmes can be actively harmful*” Would there be any question of “*imposed rigid programmes*” being forced by psychiatrists and psychotherapists upon those with motor neurone disease, Parkinson’s disease or MS to make them change the way they think about their illness? Would the CMO recommend or even condone such programmes for such patients? Why were such programmes imposed on so many CFS/ME patients in the first place? They are known to have caused harm to patients with ME (*see Annexe 3 to the report*).

page 46: “*It seems appropriate that all practitioners working with an individual are consistent in approach, and share professional perspectives*”. **This seems a very dangerous statement and a covert attempt at coercion, because it clearly indicates that all other practitioners are expected to agree with the recommendations of the CMO’s report (ie. the beliefs of the Wessely School) about CFS/ME and it places an intrinsic psychological burden on them to do so.** The less experienced could feel they had no option but to agree with psychotherapy for their patients with ME/ICD CFS as the CMO’s report officially promotes it as the best available treatment.



page 47: *“the exertion involved and impact of attending hospital (and to a lesser extent primary care services) have a negative effect on their health and on their ability to communicate effectively with practitioners. These obstacles must be overcome in practical ways....”* What *“practical ways”*? Not one is mentioned or suggested. Who will devise and fund such *“practical ways”*? Where does this leave sufferers?

page 47: *“evaluation requires an acceptance...that management is dynamic”*. Does not *“evaluation”* require competent physical examination which is supported by appropriate laboratory investigation using the best diagnostic facilities available?

page 48: as anticipated, the CMO’s report recommends only limited investigations in cases of CFS/ME: it repeatedly advises that there is no need to perform any specialist investigations such as neuroimaging or immunological investigations, because it accepts and recommends that the best management strategies are entirely psychiatric.

The ME community may find such recommendations to be indefensible: attention is drawn to the work of Cook et al, who have demonstrated that brain abnormalities detected by MRI are significantly related to low physical function in ME/ICD CFS patients. Abnormalities were grouped into five categories:

- (i) lateral ventricular enlargement
- (ii) grey matter and / or brain stem hyperintensities
- (iii) subcortical white matter hyperintensities
- (iv) cerebral atrophy
- (v) L - R cerebral hemisphere asymmetries.

52% of patients examined showed abnormalities that fell into one of the five categories. The authors suggest that brain abnormalities in ME/ICD CFS are *“as functionally significant as has been shown in the case of multiple sclerosis”*. (ref: Relationship of brain MRI abnormalities and physical function status in chronic fatigue syndrome. Cook DR et al. *Intern J Neuroscience* 2001:107:1-6).

However, unless the CMO personally intervenes, his report will specifically advise UK clinicians not even to look for such pathology in cases of CFS/ME.

page 49: re symptoms: in order to assist clinicians, why not list all known and published symptoms, which are documented as totalling over 64, together with a list of the documented observable physical signs? However, this omission may be deliberate and expedient, because symptoms such as are known to occur in ME/ICD CFS cannot possibly be modified by the psychological management strategies which the CMO’s report recommends.

page 52: *“factors that appear to be associated with poor prognosis include...certain strongly held attitudes to the illness”*. The Wessely literature does indeed claim this, but

the international literature specifically does not support such a claim. Yet again, not to mention this is not only selective but deceptive.

page 53: “*Assessment for mental health problems at an early stage is important*”. Is it “important” that every patient with cancer or MS is subjected to a mental health assessment?

page 53: “*much, if not all, of the initial clinical evaluation and diagnostic process can be satisfactorily undertaken by the primary care team*”. Currently, a GP is allowed seven minutes per patient; at their recent Conference, GPs were threatening a mass exodus from the NHS because they are so overburdened. It is acknowledged that assessment of those with CFS/ME is especially time-consuming. How can it be practical or even feasible for the CMO to place such an additional burden on GPs? What this means is that CFS/ME sufferers will simply not be investigated and will continue to be abandoned, as many currently are (which the report itself acknowledges). Moreover, without diagnostic support and confirmation from a hospital consultant, patients might be ineligible for state and insurance benefits.

pages 57 / 58: re the severely affected. as noted above, the Working Group appears to take the easy option and states “*we found insufficient evidence available to guide specific management of those people who are severely affected*” and they fail to address their specific remit by off-loading responsibility onto others: “*Healthcare and social service professionals are responsible for finding ways of supporting and guiding patients and their carers for the duration of their illness*”. Who will fund such support? Social Services are denying even one hour a week of home help to 90 year olds living alone on the grounds that there is no money, and care homes are being closed almost weekly on the grounds that owners will no longer subsidise the Government by relieving it of its financial responsibilities. With already insufficient social service budgets, there is no hope of this happening and both physicians and the informed public know this to be so.

page 59: “*The Group also found it important for clinicians to use the pharmacological ...means available to relieve disabling symptoms*”. This would have been an appropriate place to mention the enormous problem of adverse drug reactions in CFS/ME, but no mention is made here of this important feature of the disorder (although there are minimal references to it elsewhere in the report).

page 60: The Working Group found three specific strategies to be “*potentially beneficial in modifying the illness: graded exercise, cognitive behavioural therapy, and pacing*”.

re: Graded exercise: the CRD at York found only **three** random controlled trials (RCTs) to support this, yet the CMO’s report states “*The majority of the Working Group agreed that appropriately supervised graded exercise therapy...can benefit many, though not all, ambulant outpatients with CFS/ME*”. Is this because the majority of the most influential members of the Working Group have built their careers on insisting that “CFS” is a psychiatric disorder and have been financially supported for years by the Linbury Trust?

The Linbury-funded psychiatric research is notorious for completely ignoring the severely affected. The report itself concedes the very high drop out rate from this intervention.

re: Cognitive behavioural therapy (CBT): The CRD at York identified only **four** RCTs on which it could rely. Again, drop-out rates are notably high. The report states that *“There was disagreement among clinicians as to the precise value and place of cognitive behavioural therapy”* yet it goes on to state *“The Working Group accepts that appropriately administered CBT can improve functioning in most patients with CFS/ME who attend outpatient clinics”*. Such a statement implies consensus amongst the entire Working Group but this is far from the case.. Once again, the severely affected are simply dismissed: *“The place of the therapy for patients more or less severely affected than those who participated in research is currently uncertain”*. How, then, can the report conclude that GE and CBT have been identified as “specific strategies which modify the illness” (as claimed on page 59)?

re: Pacing: this is not a “treatment” --- it is plain common sense. The report states *“The first goal of subsequent stabilisation...is to establish a baseline of sustainable activity”*. yet many ME/CFS sufferers cannot perform any *“sustainable activity”* --- that is one of the key features of the disorder. The report goes on to state that for those who remain severely unwell, *“pacing therapy may also involve passive physiotherapy”*. Given that ME/CFS patients are regularly struck off their GP’s list and that domicilliary visits are regularly refused to those with ME/CFS, no matter how sick or housebound they may be, what realistic hope is there of GPs advocating funding for *“passive physiotherapy”*?

The report goes on to suggest that *“The principles of, and tools used in, pacing...can be incorporated into a care plan for CFS/ME patients in both primary and secondary care”*. To educated and intelligent people, this appears fatuous: desperate sufferers are used to “pacing” themselves and do not need psychological “tools” to work out their limitations.

The report makes the point that some clinicians (clearly psychiatrists and adherents of the Wessely School) are not convinced of the benefits of pacing on the grounds that it *“may prolong a patient’s illness”* (presumably by pandering to the patient’s “aberrant belief” that they suffer from an organic illness as a result of which they are extremely physically compromised).

page 66: Symptom control: The report states *“some symptoms are intrusive and unpleasant ...and may act to impede recovery...Substantial efforts should be made to elicit and manage difficulties with...mood”*. Does this happen in patients with cancer or other neuroimmune disorders? If not, then why is this approach re-iterated again and again for those with ME/CFS? How can this group of doctors (ie proponents and adherents of the Wessely School including Tony Pinching, Professor of Immunology at St.Bartholomew’s and Deputy Chair of the CMO’s Working Group, who is on record as stating that “90% of CFS is psychological” and that “there is no need for research” into CFS/ME) continue to ignore the international literature on ME/ICD CFS, or is it the case that they must subscribe to a pre-determined agenda? The editorial team is at pains to

point out in Online Annex 6 (Report Summary) that *“This clinical guide refers to the disorder as CFS/ME in line with the remit given to the Working Group (emphasis added). Who is responsible for that specific instruction in the remit? Why was it mandatory?*

page 67: The report states *“If intolerance to medication is a major difficulty for the individual, other strategies are worth exploring...as appropriate”* but none is mentioned or suggested as guidance.

page 67: re: Counselling: *“Counselling describes both a skill used by clinicians in their daily work and a structured form of therapy.....further research is warranted in the form of a larger, randomised, controlled trial to examine the possible benefits of counselling...in CFS/ME”*. This seems incompatible with what Wessely wrote about counselling in the BMJ in 1996 (*ref: The rise of counselling and the return of alienism. Simon Wessely. BMJ 20 July 1996:313:158-160*). In that article, Wessely referred only briefly to CFS but stated the following about counselling:

*“At issue is a fundamental question about mental health services....Who really is in need? Who is best able to meet that need? Should patients always get what they want anyway? The rise of counselling has attracted both attention and criticism...Having joined the ranks of others who noted the lack of evidence for the efficacy of counselling, (the authors of a recent editorial) concluded that ‘ all counsellors in primary care should be properly trained, supervised and supported’ ... However, a properly trained and supervised person who delivers an ineffective treatment is hardly a sign of progress... The evidence in support of counselling is scarce...Data from randomised controlled trials suggest that specific psychological treatments such as cognitive behavioural therapy...can be effective for these disorders (and) replacing an intervention of proved efficacy with one whose efficacy is much in doubt is not a satisfactory outcome measure... Patients with chronic somatisation disorders have few equals in terms of cost to the health service... withdrawing (psychological interventions and services and replacing them with counselling) may reduce any influence the (psychiatric) profession might have across the range of mental disorder. We must ensure that the growth in counselling does not divert resources away from access to such treatments as behaviour therapy... The consequences of these changes will be an inevitable reduction in the scope of psychiatry..and indeed the attraction of a psychiatric career” (emphasis added).*

Now, however, the report of the CMO’s Working Group on CFS/ME (of which Wessely is a member) is recommending counselling, claiming that the Working Group has identified it as a “beneficial strategy” in “modifying” the illness. On what evidence? None is provided.

page 68: The report states *“A gradual and mutually negotiated return to work or education can improve outcome”*, yet the immediately preceding paragraph makes the point that *“the fluctuating nature of CFS/ME means that remissions and setbacks may*

*commonly occur*” . How can those who commonly experience setbacks be reasonably expected to return to work or education? What about the 25% of sufferers which the report itself acknowledges are bed or housebound?

page 68: The report advises that *“The same level of understanding needs to be shown by medical advisers to insurance companies and the Benefits Agency about the condition...and (about the) range of available approaches to recovery”*. The CDC CFS Programme Update of August 2001 (which appeared at exactly the same time as the final draft of the CMO’s report appeared, so the evidence on which the US document is based must have been available to the authors of the UK report) is very clear about the clinical course of CFS/ME: as mentioned above, **only 4% of CFS/ME patients had full remission (not recovery) after 24 months**. There is currently ***no*** *“range of available approaches to recovery”*. Why will those advising the UK CMO not accept that this is the worldwide reality and that the only way forwards is by rigorous investigations?

page 69: The report found *“There is insufficient good quality evidence available to guide precise estimates of service need”*. It was some of these same authors who in their 1996 Joint Royal Colleges’ Report on CFS recommended that NHS commissioning officers had no need to consider service need or provision for those with CFS.

page 69: (Developing local services): the report states *“Ideally, services would...adopt a biopsychosocial model... of care. The general components of such a service are...facilities for energy / activity management”*. There is no recommendation (or even acceptance of the need) for the urgent establishing of centres of excellence which would provide facilities to look at the underlying immunology, neurology, endocrinology or the molecular biology of ME /ICD CFS, only for more psychiatric services.

In the light of available world evidence which has clearly demonstrated many biomarkers in this complex disorder, the chapter on management lacks scientific credibility.

### **Attempts to pave the way for acceptance of the management strategies recommended in the CMO’s report**

Mention must here be made of the 19<sup>th</sup> September 2001 issue of JAMA (Journal of the American Medical Association), which published the review of the literature carried out by the team from the Centre for Reviews and Dissemination which was commissioned for the CMO’s Working Group on CFS/ME (to which Wessely was an adviser): the article is entitled Interventions for the Treatment and Management of Chronic Fatigue Syndrome: A Systematic Review (Penny Whiting et al); it has received wide criticism in the international media on the grounds that its conclusions are dubious, premature and unwarranted and are open to being misconstrued: many of the CBT trials were flawed in their methodology and in the interpretation of results; the long-term effects of CBT are unknown, whilst the severely affected have not been included in any of the cited studies.

In an apparent attempt to pre-empt or ameliorate such criticism, in his accompanying Editorial entitled Chronic Fatigue Syndrome - Trials and Tribulations, Wessely inevitably wrote in support of the review:

“The..review comes to two firm conclusions. The first is that those treatments that the authors group together as broadly behavioural in nature – namely, either graded exercise therapy (GET) programmes or cognitive behavioural therapy (CBT) – are currently the most effective treatments (*sic*) that have been submitted to the test of the clinical trial.

“...consumer advocacy groups might join forces to lobby for better provision of the two interventions –GET and CBT – that have shown promising results...”

“ it is regrettable but likely that this review article will not be universally welcomed. Some consumers, and researchers alike, will make it their mission to discredit the authors and their conclusions.

“The time has come for clinicians who wish to help their patients with CFS, and for activists who truly represent the interests of patients, to begin by welcoming this review.

“Failure to respond positively to the challenges posed by this review will mean that activists and their chosen researchers will continue their own dialogue among themselves, closing their minds to alternative views and approaches, despite supportive evidence (of the efficacy of CBT and graded exercise).

“The interventions that appear to have benefit...are safe (and) sensible” .

Attention is drawn to the various critiques of Wessely’s Editorial in JAMA, especially the one on Co-Cure on 19 September 2001 by Judith Wisdom (a Clinical Sociologist of Medicine), which exposes Wessely’s ignorance of fundamental canons of scientific discourse and his violation of them. Wisdom states she does not know how Wessely can claim that studies of CBT have been shown to be the most effective treatment since he himself knows that there are problems with the sample populations and with the lack of control for variables. She comments “ Why JAMA publishes this man’s inferior work is baffling....Wessely’s fancy talk of methodology is no substitute for science”.

Writing to the Editor of JAMA about Wessely’s Editorial, Dr Charles Shepherd makes the point that Wessely is being disingenuous to infer that the reason the findings will be criticised is due to misguided passions over the possible causes of CFS; Shepherd states that rather than basing its conclusions on results from a very limited number of studies, the ME Association also takes account of evidence which includes feedback from both patients and clinicians, and that the evidence upon which Wessely bases his promotion of graded exercise (ie. that patients are unfit and de-conditioned) is not consistent with

objective measures of physiological functioning. In an accompanying note to editors about potential conflicts of interest Shepherd comments that “Simon Wessely...does not refer to the fact that he is a member of the Advisory Panel to the York Systematic Review – surely that should have been noted”. (*Co-Cure*, 24<sup>th</sup> September 2001).

In an obviously disingenuous attempt to counter public criticism, Wessely himself posted an item on Co-Cure on 20 September 2001:

“ My editorial was a heartfelt plea to try and avoid that kind of passionate discourse that it appears to have sparked....I still hope that my better intentions are seen for what they were...an attempt to express something very simple...CBT and graded exercise are reasonable approaches that can help some folks....my words were intended to lower, not raise, the temperature, and to appeal to people to step back a minute and recognise that the whole CBT/GET issue is not such a big deal...(and) at present are the best we can reasonably offer...”.

Wessely cannot disown or deny the denigratory nature of much of his published works on ME/CFS over the last 14 years, and this current attempt at affable geniality must be seen with the context of his well-known and published views. Nothing changes that evidence.

A posting on 22 September 2001 on an internet list commented on Wessely’s own posting:

“This is about hypocrisy and intolerance. He claims CBT/GET are the best treatments available and therefore “sensible”, ignoring evidence to the contrary, denying it even, implying that anyone who doesn’t share this view is not “sensible”. (Any) criticism (of his view) apparently is not evidence-based, it’s emotional or misguided (an old trick of his). He preaches evidence-based medicine and co-operation but practices intolerance and theory-led psychobabble. What happened to the other studies which found other treatments as effective but which he and his friends refused to pass when acting as referees?”.

In a Co-Cure posting on 27<sup>th</sup> September 2001 a Dutch scientist made the following points:

“ I am a scientist with an allegiance to a patient support group. According to your editorial, this means that I am likely to be biased and intolerant. It is sad that you are not prepared to consider that some of your critics may have a valid argument. In your post to Co-Cure, you described CBT / GET as ‘reasonable approaches that can help some folks’. The editorial did not refer to the efficacy of CBT / GET in ‘some’ folks, but suggested it was an intervention (which is) appropriate, ‘safe, sensible and modestly effective’ for more or less everyone with CFS. There was no mention of the many for whom it is not effective, no mention of the high drop out rates...Why is (CBT) a sensible treatment for people with...symptoms like bladder disturbance, vision problems, positional vertigo, seizures etc. Are you implying

that these are all somatoform?.....Why is (CBT) sensible for people with on-going immune activation or muscle disease?....Your editorial did not discuss the material you claim to have discussed....But you took the opportunity given to you by the editor to hype CBT / GET. You ignored the major flaws of the ‘successful’ CBT trials....We want doctors to acknowledge that (CBT) is not appropriate and effective for everyone (so) we are not going to lobby for ‘better provision’ for CBT and GET as you suggest we should in your editorial. Perhaps your critics are ‘passionate’ because they care. To imply, as you do, that those with opposing views are merely emotional and agenda-driven, whilst you are objective and evidence-based, seems a little intolerant”.

As noted in a posting on Co-Cure on 22 September 2001 by the Chief Executive Officer of the CFIDS Association of America:

“Anything that suggests that you can exercise yourself out of an illness carries the risk of suggesting that an illness is all in a person’s head, and that is not the case here”.

Nevertheless, this is the message that has been picked up by medical journals, the internet and by world news agencies and press releases including Reuters, PR Newswire and Associated Press. Headlines include:

“The best ways to treat chronic fatigue syndrome (CFS) may be exercise and seeing a shrink”. (*HealthScoutNews, 20 September 2001*)

“Chronic fatigue: Best way is to sweat it out. A JAMA editorial said the review may be interpreted as confirming the bias that chronic fatigue syndrome is psychological in nature”. (*The Economic Times / Times Internet Ltd, 24 September 2001*).

“Cognitive behavioural therapy and graded exercise therapy show promise for the treatment of chronic fatigue syndrome” (*Lancet, September 23, 2001: 358:9286:989*).

“Media reports have already claimed that CBT and exercise are the ‘best’ treatment and, therefore, the syndrome must be psychological” (*Needham, Mass. US Newswire, 20 September 2001*).

“Exercise therapy and a type of behavioural therapy show promise for relieving the symptoms of chronic fatigue syndrome” (*Reuters Health, New York, 19<sup>th</sup> September 2001*).

“Research on chronic fatigue syndrome indicates that behaviour-based therapies, including exercise, may be among the most effective treatments” (*Chicago (Associated Press), 21<sup>st</sup> September 2001*).



“A review of the evidence suggests that cognitive therapy and graded exercise are the only treatments for chronic fatigue (*sic*) that produce some improvement” (*Health and Age: Novartis Foundation for Gerontology, 20 September 2001*).

Thus the mantra of the Wessely School has once again been proclaimed to a worldwide audience.

### **Chapter 5: Children and young people**

Much of this chapter is very good and is a great improvement on the comparable chapter on children in the 1996 Joint Royal Colleges’ Report on CFS (which spoke of Munchausen’s Syndrome by Proxy, forcible removal of the child from its parents and home and the immediate return to school). The CMO’s report accepts the fact that some children will be too ill to participate any form of education, even in home tuition, and it specifically warns that neither the fact that a child has unexplained symptoms nor the exercising of parental choice about treatment constitutes evidence of abuse; it notes specifically that evidence clearly suggestive of harm must exist before initiating child protection proceedings.

However, this chapter also repeats the pervasive message: it starts by advising that the chapter must not be read in isolation but that the rest of the report should serve as the context regarding aspects of care. This is re-inforced in the box of Key Messages, which state that ideal management is multi-disciplinary and that care is best delivered according to a specific treatment plan (which may involve psychiatrists) and the chapter goes on to affirm that as with adults, symptoms are affected by the individual’s response to the illness.

It states that children and young people will benefit from referral to the Child and Adolescent Mental Health Services, and that a psychiatric opinion can be the key to diagnosis.

### **Chapter 6: Recommendations of the Working Group**

In this chapter, the report acknowledges that the Working Group had encountered extensive evidence on the extent of distress and disability that this condition causes to patients, carers and families.

It states that the Working Group “*has examined the evidence on the effectiveness of interventions used in the management of this condition*”.

It summarises the Working Group's perception of the recognition and definition of the illness, and it outlines the report's preferred treatment options, stipulating that those who feel they need extra skills in treating affected patients should seek help from "*those experienced in this area*". It states that clinicians must give "*appropriate and clear advice, based on best national guidance*". Due in no small measure to the assiduous activities of the psychiatric lobby, the only "national guidance" which the report acknowledges is that provided by the psychiatric lobby itself.

Regarding Health Service planning, the report recommends that "*Service networks should be established...to access when necessary the skills, experience and resources of secondary and tertiary centres, incorporating the principles of stepped care...*" ("stepped care" is a principle of progressive psychiatric care)...*Health service commissioning ..must ensure that local provision for these patients is explicitly planned and properly resourced*". This may be interpreted as recommending that more provision for psychiatric facilities should be explicitly planned and properly resourced.

The report recommends that "*Healthcare professionals...should receive postgraduate education and training*" and that "*Awareness and understanding of the illness needs to be increased among the general public through schools, the media, and employers, agencies, and government departments*". If the CMO accepts the recommendations of this report, such postgraduate education is likely to concentrate only on psychiatric aspects as perceived by the Wessely School.

The report states that "*A programme of research on almost all aspects of CFS/ME is required....Government investment in research on CFS/ME should encompass ..,behavioural and social science, clinical research and trials, and basic science*". There is no mention of the need for research into the known organic abnormalities.

Specifically, the report recommends that "*the research programme should include... sufficient resource allocation for investigator-generated studies on the condition*". Currently, "investigator-generated studies" in the UK are firmly in the psychiatric domain.

If this report is accepted by the CMO, then that is where they will stay.

## **Online Annexes**

In this final draft, some references are incomplete.

### **Annexe 1: Epidemiology**

"*Information on the incidence and prevalence of CFS/ME is fragmentary and contradictory*". If the authors are considering the amalgamation of two conditions, this may be so, but there is information about ME dating back 60 years.

*“The original description of ME was published by Ramsay and colleagues”*. The original description of the condition was that of AL Wallis in 1957.

*“...doctors are becoming more accurate at diagnosing CFS/ME and distinguishing it from other psychological illnesses...”*. Neither ME nor ICD CFS is a “psychological illness” and neither is classified as such.

### **Annexe 2: Prognosis of CFS/ME**

Under “Predictors of chronicity” are listed *“having a solicitous partner”*, *attributions of complaints to a somatic (organic) cause*; *“behavioural disengagement”*; the annexe states that a “systematic review” by Joyce and colleagues (ie. psychiatrists Hotopf and Wessely in the Quarterly Journal of Medicine, 1997) concluded that *“holding a belief that the illness is due to physical causes”* was a risk factor for poor prognosis. No mention is made of the studies which disprove that claim or of the stringent criticisms of Wessely’s work which were published in the subsequent issue (*ref: Chronic fatigue syndrome. TE Hedrick. Q J Med 1997;90:723-727*).

The annexe twice mentions an Australian study which concluded that *“psychological factors such as illness attitudes and coping style were more important predictors of long-term outcome than immunological or demographic variables”*. That study consisted of only 113 patients. Other Australian studies (eg by McGregor and Dunstan presented at the Second World Congress on CFS, Brussels, September 1999) show that CFS is not psychiatric but is soundly based on markers of biochemical dysfunction.

### **Annexe 3: Patient evidence**

This annexe is a very short summary of the patients’ evidence which omits much important and useful information contained in the main body of the report.

### **Annexe 4: General concepts and philosophy of disease**

This annexe seems to derive from a discussion draft written by Professor Tony Pinching on 2<sup>nd</sup> December 2000.

On the vexed issue of terminology, the report includes Pinching’s personal view: *“However, for at least some patients with established disease, any name that has been applied will understandably become incorporated into their lives and belief systems”*. As was pointed out to Professor Pinching and the Key Group, it is not a matter of a particular name becoming incorporated into a patient’s “belief system”: it is a matter of recognising that the term “ME” is known to represent a particular constellation of signs and serious symptoms which are not contained in the case definition of “CFS” as used by psychiatrists of the Wessely School. It is also a matter of accepting the need not to equate one specific syndrome with another of the same title when the two do not share the same clinical features.

On the important issue of sub-groups, Pinching wrote “*On present evidence, this question (of sub-groups) may be considered a matter of semantics and personal philosophy...*”.

This does not accord with the substantial body of informed international opinion, namely that sound research has strengthened the need for the consideration of sub-groups. Leading international researchers and clinicians such as Patarca, Jason, Friedberg, Natelson, de Meirleir, de Becker, Levine etc are unequivocal on this issue, and referenced evidence of this was put before the Key Group but was consistently ignored.

On the matter of existing diagnostic criteria, the annexe refers to “*the original description of ME (Dowsett et al, 1990)*”. The original description of ME was not in 1990: it was in 1957; the Royal Society of Medicine held a symposium on ME on 7<sup>th</sup> April 1978, at which ME was accepted as a distinct entity. The symposium proceedings were published in The Postgraduate Medical Journal in November 1978, and the Ramsay case description was published by the ME Association in 1981. ME was formally classified as a neurological disorder in 1969. It seems that the editorial team has again been careless.

#### **Annexe 5: Management of CFS/ME – evidence base**

This annexe specifically states the Working Group’s intention was to “*develop as annexes to this report resource tools to guide diagnosis and clinical management*”. It confirms its approval of the Systematic Review of the literature: “*The Key Group found the report to be a good review of evidence from randomised trials...*”. This annexe includes the abstract of the York review, and it accepts the effectiveness of CBT and GET as best practice interventions in CFS/ME.

#### **Annexe 6: Management of CFS/ME – Report Summary**

This annexe is described as a “Guide for Clinicians” and a “Management Tool”; it condenses the views of the main report on Definition, Aetiology, Approach to management, Treatment and care, Information and support, Prognosis and On-going care; it is described as representing the “current perception of ‘best practice’; it recommends only basic screening and essentially it promotes the psychiatric party line.

#### **Annexe 7: Management of CFS/ME – children and young persons summary**

This annexe reproduces some of what is contained in the main body of the report concerning children; inevitably it mentions referral to the Child and Adolescent Mental Health Services.

#### **Summary of Comments**

Whilst some aspects of the report are a great improvement on the 1996 Joint Royal Colleges’ Report on CFS, this report is constructed with an admirable astuteness because it is crafted throughout to leave interpretation of its content in the mind of the reader: it

may therefore leave existing prejudices intact as it accommodates the prevailing psychiatric domination of management strategies, even though those strategies have been demonstrated to be at best ineffective and at worst positively harmful. It is a matter of note that, as mentioned above, the report itself records that 50% of 1214 respondents were made worse by one of the recommended management strategies, whilst 67% of 285 respondents found another recommended strategy made no change at all, and the report concedes that the effects of its recommended strategies on the severely affected are unknown.

Whilst it records the devastating effects of the disorder, it is selective in the symptoms it mentions and no-where in the report does it inform readers of the formal classification of ME as a neurological disorder, nor does it refer to the existing extensive research data which underscore the physical basis of the condition, particularly the endocrine, neuro-immunological and neurovascular anomalies, nor does it discuss the compelling laboratory evidence of delayed muscle recovery after fatiguing exercise in those with ME/ICD CFS.

This was anticipated by many in the ME community, because for the CMO's report to have informed readers of such serious multi-system dysfunction would have revealed the offensiveness of the continued promotion of inappropriate psychiatric management strategies upon which the report is based. Such management strategies are not mandatory for those with other neurological disorders for which there is currently no treatment.

Regrettably the report fails to challenge the unsatisfactory status quo as far as psychiatric management of ME and ICD CFS is concerned, indeed it actively supports and promotes the existing psychiatric management strategies.

**Brief summary of areas of investigation which have revealed abnormalities (which the UK CMO's report advises are unnecessary)**

Note: Whilst holding the post of Deputy Chair of the CMO's Working Group on CFS/ME, Professor Pinching wrote: "**over-investigation can (cause patients) to seek abnormal test results to validate their illness**". (*ref: Chronic fatigue syndrome. Anthony J Pinching. Prescribers' Journal 2000:40:2:99-106*)

In contrast, world-class experts have found abnormalities which are legion and have advised that **basic screening is insufficient for such a complex disorder and that detailed investigations are required.**

Areas which have been shown to require investigation include the following:

Brain studies / nuclear imaging; detailed neurological investigations, including central, autonomic and peripheral nervous system testing; visual processing (there is evidence of altered connective tissue turnover); in-depth biochemical testing (anti-oxidative enzymes;

lipid analysis); on serum chemistry testing, there may be elevated levels of transaminases; virological investigation (for antibody titres); studies of altered gene expression; microbiology (RNaseL pathway investigation); urinary markers (creatinine has been shown to be a sensitive marker of muscle inflammation); comprehensive (as distinct from basic) endocrine / metabolic testing including full thyroid and adrenal status; there is evidence of hypothyroidism (specifically, the common neuroendocrine tests have been shown to be inadequate for ME/ICD CFS patients); water-loading testing; buspirone/prolactin response; pancreatic exocrine function status; testing for vascular abnormalities, including testing for hypercoagulability; lung function tests; tests of exercise capacity, including measurement of maximal oxygen uptake and investigation of oxygen delivery to muscle; tests for cardiac anomalies; functional tests of liver (including copper response test) and gut; nutrient deficiency testing (including trace element status) and complex immunological investigation, including testing for allergies and multiple hypersensitivities.

Specifically, immune function and status require careful and serial evaluation. The pattern of immune marker abnormalities observed is compatible with a chronic immune activation state. Equally, the disorder has been described by Professor Nancy Klimas as “a form of acquired immunodeficiency, with NK (natural killer) cell dysfunction being the most consistent abnormality” (*ref: Immunologic Abnormalities in Chronic Fatigue Syndrome. Nancy G Klimas et al J Clin Microbiol 1990:1403-1410*).

A large number of ME/ICD CFS patients have an abnormal immunological profile, including a perturbed apoptotic process. There is evidence of autoimmunity: studies with immunohistochemistry have shown a high percentage of ME/ICD CFS sera reactive to centrosomes (with a high frequency of reactors in lupus and rheumatoid arthritis as well as in ME/CFS). there is evidence of antilamin antibodies (found in the blood of ME/ICD CFS patients): **antibodies against this protein are proof of autoimmunity and of damage to brain cells**. The occurrence of autoantibodies to an intracellular protein like lamin B 1 provides **laboratory evidence** for an autoimmune component in ME/ICD CFS. Autoantibodies to nuclear envelope (NE) proteins are relatively infrequent in routine anti-nuclear antigen serology. There is also evidence of antithyroid antibodies in ME/ICD CFS.

It has been demonstrated that changes in different immunological parameters correlate with particular aspects of disease symptomatology and with measures of disease severity. Further consolidation of the correlation between symptomatology and evidence of immune dysfunction is to be found in the convincing work of Natelson et al who have demonstrated the link between IL4 and a type 2 cytokine pattern (a preponderance of a Th2 response is consistent with autoimmunity). Cytokine profiles are often abnormal.

Screening of the activity of individual NK cells *per cell* (not just gross killing) is necessary, as is measurement of the CD4-CD8 ratio. Abnormalities of the immunoglobulins are frequently seen, especially of IgG, including IgG3. Circulating immune complexes are seen.

Haematology reveals leukocytosis and leukopenia; relative lymphocytosis has been found, and atypical lymphocytosis has been found in at least 50% of patients during serial studies; monocytosis has been found in 48% of patients; tests for heterophile antibody or monocytosis are positive.

**Ninety two pages of mainstream medical and scientific references were sent to the CMO's Key Group; they were divided into the following sections:**

**Historical papers on ME (1955-1991)**

**General papers on ME / ICD CFS (1991 →)**

**Laboratory findings in ME/ICD CFS**

**Neurological factors / findings in ME/ICD CFS**

**Evidence of demyelination and cerebral oedema in ME/ICD CFS**

**Quality of life in ME/ICD CFS**

**Respiratory problems in ME/ICD CFS**

**Neuroendocrine factors / findings in ME/ICD CFS**

**Severity and chronicity in ME/ICD CFS**

**Virological aspects of ME/ICD CFS**

**Stress enhances susceptibility to viral infection (especially CBV)**

**Stress as a precipitating factor of ME/ICD CFS**

**Liver involvement in ME/ICD CFS**

**Immunological abnormalities in ME/ICD CFS**

**Hair loss in ME/ICD CFS**

**Vascular problems in ME/ICD CFS**

**Cardiac problems in ME/ICD CFS**

**Ocular problems in ME/ICD CFS**

**Cognitive dysfunction in ME/ICD CFS**

**Nuclear medicine findings in ME/ICD CFS**

**Useful psychological papers on ME/ICD CFS**

**Allergy and hypersensitivity in ME/ICD CFS**

**Problems with anaesthesia in ME/ICD CFS**

**Similarities and differences between ME/ICD CFS and Fibromyalgia**

**Examples of medical misdiagnoses --- the literature abounds with evidence that patients have often been given an inappropriate psychiatric label which abruptly disappears when medical science discovers the underlying pathology. Examples include diabetes; hypothyroidism; pernicious anaemia; peptic ulcer; Parkinson's disease and multiple sclerosis.**

Malcolm Hooper

29<sup>th</sup> September 2001

