More facts for Professor Simon Wessely (which uncover evidence of an "anomaly")

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On 31st August 2003 the mother of a son with long-term ME/CFS (Connie Nelson from Glasgow) wrote to Tony Wright MP, Chairman of the All-Party Parliamentary Group on ME (APPG) at the House of Commons, asking him to make it a priority to raise awareness within Parliament and within Government that there was a serious problem to be found on the website of the National Health Service Information Authority (NHSIA) concerning the misclassification of ME/CFS as a mental disorder.

The NHSIA was set up in 1999 under the Labour Government of Tony Blair to dispense "information" which Government wished to be disseminated throughout the NHS. The NHSIA has produced The Mental Health Minimum Data Set Data Manual, in which it is erroneously stated that ME/CFS is a mental disorder classified in the WHO ICD-10 under code F48.0 (ie. under mental, behavioural and neurotic disorders).

Mrs Nelson also asked Tony Wright MP to make pressing enquiries at the NHSIA as to why, five months after a complaint was registered, the misinformation was still being promoted by the NHSIA in its Mental Health Data Manual, given that the classification codes are easily verifiable from the WHO Headquarters in Geneva.

On 12th September 2003 a reply in the following terms was sent to Tony Wright MP by Stephen Harrison, Head of Corporate Affairs and Governance at the NHSIA:

"Within NHS secondary care, ICD-10 is the mandatory standard for coding diagnostic statements. Within this classification, the condition Chronic Fatigue Syndrome (CFS) or Benign myalgic encephalomyelitis is coded within the diseases of the nervous system chapter (G93.3).

"It appears, however, that the Mental Health Minimum Data Set: Data Manual, Version 2.0, July 2001, produced by the Authority and which appears on our website has referenced the Guide to Mental Health in Primary Care produced by the Institute of Psychiatry, London. In this UK adaptation, CFS has been assigned with the code F48.0 under the Chapter for mental disorders.

"This, of course, causes an anomaly with the full ICD-10.

"It is this anomaly that the Authority has been trying to clarify with the Institute of Psychiatry".

Of particular interest and concern to the ME/CFS community is the proposed resolution by the Institute of Psychiatry of this "anomaly".

It seems that in the UK, "CFS" is to be given ***two*** classifications: if it can be proved to follow a viral infection, then ME/CFS will be coded under G93.3 as a neurological disorder, but if the same symptoms cannot be proved to follow a viral infection, then ME/CFS will be coded and classified as a mental disorder under F48.0.

This will obviously result in the dual classification of the same disorder, **something that the WHO Headquarters has confirmed is *(quote)* "unacceptable".**

Such a resolution of the existing anomaly might be seen as nothing more than a face-saving exercise by the psychiatric lobby led since 1987 by Simon Wessely (whose determination to re-classify ME/CFS from neurological to psychiatric is a matter of well-documented record), or it may be more sinister.

It is a fact that it has been demonstrated that ME/CFS can be either virally or chemically induced.

The proposed dual classification of the same disorder would, at a stoke, ensure a "mental" classification for people with chemically-induced ME/CFS, with resultant implications for those seeking State and insurance benefits. Since Government "policy" is only to carry out the most basic routine screening of such patients, the chance of proving a viral onset seems to be slight, making it less likely that those with ME/CFS could avoid compulsory psychiatric interventions such as CBT and graded exercise, which have already been shown to be harmful to those with ME/CFS.

As Hooper et al have noted, clinicians and lawyers need to come to their own conclusions about what might motivate a group of doctors to disassemble a formally classified neurological disorder and endeavour to replace it by a much larger category of psychiatric "behavioural" illness. They need also to consider how, despite there being such an extensive literature on the organic nature of ME/CFS, the same group of doctors has come to exert such influence over the rest of the UK medical community.

Lawyers may wish to consider if this group of exceptionally influential psychiatrists should be allowed to determine public policy without there being some external moderation, and why disease definition has become socially and politically constructed, a consequence being the intentional construction of "mental illness" by these psychiatrists whose allegiance to Government and both the pharmaceutical and insurance industries cannot be disputed. (ref: "What is ME? What is CFS? Information for Clinicians and Lawyers. EP Marshall, M Williams, M Hooper December 2001 – available from Malcolm Hooper, Emeritus Professor of Medicinal Chemistry, Department of Life Sciences, University of Sunderland, SR2 7EE, UK, or on line at
www.meactionuk.org.uk/What_Is_ME_What-Is_CFS.htm