

## **PROOF POSITIVE?**

### **Evidence of the deliberate creation via social constructionism of “psychosocial” illness by cult indoctrination of State agencies, and the impact of this on social and welfare policy**

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The ME community has for years urged UK Government bodies to fund research into both the epidemiology and the biomedical abnormalities that are known to exist in myalgic encephalomyelitis (ME, also listed as Chronic Fatigue Syndrome by the World Health Organisation in the International Classification of Diseases as Chronic Fatigue Syndrome (CFS) as a disorder of the nervous system), almost always to no avail, to the extent that the ME community realised that there were powerful vested interests at stake which were known to involve a group of psychiatrists known as the “Wessely School”. Now, it seems, there is hard evidence of the reason for the Establishment’s apparent resistance to acknowledge ME/CFS as an organic disorder and, as previously realised, it does indeed involve psychiatrists of the “Wessely School”.

The evidence is contained in a book entitled “Biopsychosocial Medicine: An integrated approach to understanding illness” edited by psychiatrist Peter White, Professor of Psychological Medicine at St Bartholomew’s and the London, Queen Mary School of Medicine recently published by Oxford University Press (2005).

This provides a most illuminating exposition of what had long been suspected; the list of contributors is itself equally confirmatory.

The book arose out of a two-day conference held at the (pharmaceutical) Novartis Foundation in London on 31<sup>st</sup> October and 1<sup>st</sup> November 2002, being a joint venture between the Novartis Foundation and a body called One-Health, said to be a not-for-profit company that (quote) “was established in order to promote a system of healthcare based on the biopsychosocial model of ill-health”. Peter White is Chairman of One-Health and his fellow Directors include Trudie Chalder, a former Registered Mental Nurse who is now Professor of Cognitive Behavioural Psychotherapy at the Institute of Psychiatry and Guy’s, King’s and St Thomas’ School of Medicine. The Patron of One-Health is Greville Mitchell, described as “an influential and far-sighted philanthropist”. One-Health is supported by the Andrew Mitchell Christian Charitable Trust, based at The Grange, St Peter Port, Guernsey.

In his Preface, Peter White claims that because the biopsychosocial approach is better established in psychiatry and in the provision of healthcare for what are described as “medically unexplained symptoms”, the conference concentrated on examining the relevance of the biopsychosocial approach to such chronic “medically unexplained” symptoms which - - inevitably, given the known beliefs of the contributors -- included Chronic Fatigue Syndrome.

Peter White states that the book was written because “some people believe that medicine is currently travelling up a ‘blind alley’ (and) this ‘blind alley’ is the biomedical approach to healthcare. The biomedical model assumes that ill-health and disability is directly caused by diseases and their pathological processes (but) there is an alternative approach....the

biopsychosocial approach is one that incorporates thoughts, feelings, behaviour, their social context and their interactions with pathophysiology”.

Twenty eight “international experts in the field” were invited; twelve talks were given, followed by an equal time spent in discussion. The book includes those (edited) talks and discussions.

Some of the invited noblesse “in the field” are already known to the ME community: apart from front-runners such as Professor Simon Wessely, who chaired the entire conference, Professor Michael Sharpe and Professor Trudie Chalder, others who have featured in the fate of those with ME include Professor Mansel Aylward, formerly of the Department of Works and Pensions (which will ring bells for those with ME/CFS who have had to appear before DWP Tribunals in order to obtain or retain their State benefits) and who is now at Cardiff as Professor and Director of Psychosocial Disability and Research at a new Centre funded by UnumProvident, the medical insurance giant that has a lengthy and disturbing track record of refusing to pay legitimate claims, especially to those with ME/CFS, to the extent that punitive damages have been awarded against it.

Another of the “international experts in the field” is Professor Jos Kleijnen, Director of the Centre for Reviews and Dissemination at the University of York, the same Centre that carried out the systematic review of the literature that sought to show the efficacy of cognitive behavioural therapy for the Chief Medical Officer’s “independent” Working Group on “CFS/ME” (to which Wessely donated his personal database of over 3,000 papers), a review which concluded that cognitive behavioural therapy was the management regime of choice for those with “CFS/ME”. It is the same Professor Kleijnen who, during that systematic review of the literature, failed to acknowledge or answer correspondence that drew attention to the published peer-reviewed evidence of the organic basis of ME/CFS and of the biomedical abnormalities that have been demonstrated to exist in the disorder.

Yet another “international expert in the field” is Dr Michael Fitzpatrick, a general practitioner at Barton House Health Centre, 233 Albion Road, London N16 9JT, better known for his association with the on-line magazine “spiked” and for his public attack on the CMO when the latter stood up in support of ME as being on a par with multiple sclerosis and motor neurone disease (for information about “spiked” and its background, and the efforts of Dr Fitzpatrick to dismiss the validity of ME/CFS, see [http://www.meactionuk.org.uk/SELECT\\_CTTEE\\_FINAL\\_VERSION.htm](http://www.meactionuk.org.uk/SELECT_CTTEE_FINAL_VERSION.htm) ).

Another “international expert in the field” is Professor Adrian Furnham, Professor of Psychology at University College, London; this is the same Professor Furnham who became famous for publishing some highly derogatory comments about people with ME: in the Daily Telegraph on 18<sup>th</sup> February 1999 he wrote an article that implied that some people might use “ME” as an excuse for professional under-achievement and lack of success and he implied that such illnesses were no more than a product of a “psychobabble industry based on medicalising mediocrity” and were not real. The ME Association’s medical adviser, Dr Charles Shepherd, lodged a formal complaint about Professor Furnham with the disciplinary committee of the British Psychological Society (BPS), claiming that Furnham had broken the Society’s Code of Conduct by expressing views that were unbalanced and insulting to those suffering from ME, and that Furnham’s view that ME/CFS was nothing more than a fashionable excuse for people who are otherwise lazy, mediocre or incompetent was totally inconsistent with the published scientific findings. After four months, the BPS concluded that

Furnham had not committed any form of professional misconduct and rejected the complaint, whereupon Shepherd asked the BPS to explain how Furnham's article could be acceptable, given that its own Code of Conduct makes it clear that its members "shall value and have respect for scientific evidence when making public statements".

It is perhaps worth pointing out that this is the same BPS that, after an inquiry lasting nine months, has very recently rejected another ME-related complaint about one of its members, in the course of which the BPS itself was shown to be in clear breach of its own Rules of Procedure. That particular complaint was submitted by Professor Malcolm Hooper about an Associate Fellow of the BPS who had on several occasions publicly and maliciously defamed him and who had repeatedly publicly implied clinical expertise that she did not have, yet the BPS rejected the confirmatory evidence that was submitted. The BPS seems to have an interesting history: there will be those who recall that a Dr Meg Barker, a speaker at the BPS annual conference held in April 2005 in Manchester, advocated "polyamory", or free love and multiple relationships: "polyamory" was described by Dr Barker as "the belief that it is acceptable or even ideal to have more than one sexual partner, with an emphasis on the recognition of multiple important relationships" (see: "Free love is fine". Celia Hall. Daily Telegraph, 4<sup>th</sup> April 2005).

Another "international expert in the field" of note to the ME community is Professor Peter Salmon, Professor of Clinical Psychology at Liverpool, known for his view that "CFS/ME" is somatisation of mental illness, whose Editorial in the May 2002 issue of the British Journal of General Practice (Doctors and social epidemics: the problem of persistent unexplained physical symptoms, including chronic fatigue) included the following: "Opinion has been divided about the validity of chronic fatigue syndrome or myalgic encephalopathy (CFS/ME) as an illness. Now, in a report to the Chief Medical Officer (CMO), an expert group has concluded that the condition is indeed a chronic illness meriting significant NHS resources, including the unreserved attention of the medical profession. The approach adopted by the group became dominated by the perspective of sufferers and led to the conclusion that the scale and severity of the condition establish its authenticity and dictate the need for NHS provision. The group's recognition of CFS/ME as a distinct syndrome runs counter to trends in recent research (citing Wessely, Lancet 1999:354:936-939). It is likely that the "reality" of syndromes such as CFS/ME reflect bias in the referral and selection processes inherent in medical specialisation. Patients with persistent unexplained physical symptoms (PUPS) believe themselves to be ill (and) seek support from fellow sufferers via the agency of syndrome-specific support groups and treatment from complementary practitioners. Thus, in contrast to the trend in recent research to view PUPS as a generic problem, both clinical practice and the activities of pressure groups are tending to perpetuate syndromes such as CFS/ME. The prevailing view in UK primary care has been that somatisation of mental illness is the basic problem. Approaches to care which focus on changing the way patients and doctors communicate about the illness and, in particular, incorporate and modify patients' beliefs within an agreed management strategy, are gaining ground (and) a number of authors have pointed to the primacy of cultural and social factors in creating ill-defined syndromes, suggesting that they are akin to other types of 'social epidemic'. The fundamental criticism of the CMO's group is that by adopting an approach that allowed consumerism in health care to define an illness, it surrendered a role reserved for the profession's established scientific methods. The uncritical diversion of NHS resources, and particularly medical manpower, will not diminish the problem, for unless the medical profession clearly understands its role in the management of illness beliefs and behaviour in the absence of demonstrable

pathology, it risks becoming both an intellectual casualty and a potent vector of this and other social epidemics”.

In a submitted response (unpublished) to the BJGP, Hooper et al noted that Salmon seemed to resent the CMO’s acknowledgement that ME/CFS is a “real” disease and that Salmon made not a single mention of any of the mounting number of biomarkers of organic pathology, nor --- even though admittedly writing in a British journal--- did he attempt to explain how his so-called “social epidemics” of physical symptoms have come to affect hundreds of thousands of people worldwide who manifest exactly the same physical symptoms when such patients do not speak or understand the same language, for example, those in Russia, Sierra Leone, Papua New Guinea, China and Japan. Perhaps the most telling matter is that for one of his allegedly supportive references, he relied on the surmising of a much-criticised American Assistant Professor of English, the notorious Elaine Showalter (author of *Hystories: hysterical epidemics and modern culture* [London, Picador, 1998] who equates ME/CFS and Gulf War Syndrome with abduction by aliens) as evidence to support his own theories, from which it could be surmised that, as a psychologist, he must be at something of a loss in the complex field of neuro-endocrine-immunology and vascular biology that defines ME/CFS.

Another “international expert in the field” is Francis Creed, Professor of Psychological Medicine at the School of Psychiatry and Behavioural Sciences at the University of Manchester; he is Director of Research and Development for the Manchester Mental Health and Social Care Trust and is also Editor of the *Journal of Psychosomatic Research*. One of his research areas is the treatment of somatisation. Creed has failed to acknowledge or respond to letters written to him as Editor asking that the *Journal* present a more balanced and less biased portrayal of ME/CFS.

Other “international experts in the field” include Professor Edward Shorter, holder of the Hannah Chair in the History of Medicine at the University of Toronto, Canada, whose views are so beloved by Elaine Showalter, such views being that the creation of disorders such as ME are ‘ a spiral of suggestion’. According to Shorter, “Patients are exposed to a diagnosis and assured by a sensation-hungry media that it represents the explanation of their problems (and) they are reassured that doctors do not know what they are talking about. This is a recipe for the disintegration of medical authority and a psycho-circus of suggestion” (I am a Duvet woman: why are 85 per cent of ME sufferers women? Elaine Showalter. *Independent on Sunday*, 25<sup>th</sup> January 1988).

So much for the already-known beliefs of the contributors, but what are they saying in this book? The following extracts provide the answer, but what they do not provide is the answer as to how attempts to alter the way a person thinks about such a serious disorder can address or assist how ill a person feels (and actually is), nor how the favoured psychiatric ‘management regimes’ can improve understanding of the pathological processes that result in end-organ failure that cause patients to feel (and to be) so sick and disabled.

Unless the disease itself is robustly investigated and understood -- and ultimately treated -- no amount of psychosocial ‘management’ will have worthwhile or lasting effects, either upon the hapless sufferer trying to cope without medical support with serious and destructive organic pathology or upon the cash-strapped and rapidly sinking NHS.

The whole concept of “biopsychosocial” intervention would seem to be a short sighted ‘quick-fix’ that is doomed to pass into oblivion once the biomedical evidence falls into place: to disregard the need for (and the importance of) the *biomedical* aspects that are already known to underlie ME/CFS and to place such undue emphasis and funding only on the *biopsychosocial* aspects has, through the auspices of members of the One-Health company, come to dominate UK Government policy and service provision, but it may soon turn out to be the company’s own death sentence because there is now so much credible biomedical evidence of serious organic pathology in ME/CFS that the beliefs of members of the One-Health company look increasingly scientifically naïve and ill-founded.

No-one disputes that supportive understanding can help patients to cope with the suffering inherent in many diseases, including cancer and heart disease: where things are different in ME/CFS is that the very reality and nature of the disorder are denied by this One-Health group, who claim it is a mental disorder and who seem consistently unable to comprehend how the imposition of such erroneous beliefs can be psychologically injurious to sufferers and that this amounts to iatrogenic damage.

From the Foreword by Simon Wessely: ‘The greatest benefit to mankind’.

Before quoting from Wessely’s words, it may be worthwhile reflecting on his choice of quotation and what he hoped to convey by its use: in the book “The Greatest Benefit to Mankind” [Harper Collins, London, 1997] the late Roy Porter noted that it was the biomedical model (not the psychosocial model) that has provided advances in the understanding -- and thus in the treatment and prevention -- of disease processes.

Wessely’s Foreword states: “I seem to have spent much of the last decade sitting on grant-giving bodies.....cognitive behaviour therapy has transformed the management of many chronic symptomatic conditions. That psychological and social factors contribute to disease is clear (but) no-one in their right minds, not even government, would dream of tackling these issues without firming anchoring policy and intervention in the social sphere. No argument there. Psychological issues matter, and matter greatly. The Whitehall studies that (Sir Michael Marmot, Professor of Epidemiology and Public Health, University College, London, another of the “international experts in the field”) has guided are seminal. What they have shown is how social differentials, both at work and at home, are major determinants of disease outcome. I have always felt that trying to influence psychological and social outcomes is a very good and satisfying career for a doctor, even if in the public eye people like myself will never achieve the respect, acclaim and rewards given to our more glamorous colleagues”. Having asked: “What role does the psycho and social play in the bio?”, Wessely actually concedes that “Perhaps in their choice of participants and Chairman (for the conference) the organizers had loaded the dice (in favour of the biopsychosocial approach).

At the end of his Foreword, Wessely makes one of his convoluted pronouncements: “Medical care remains dualistic, perhaps more so than ever. In the clinic, but not the conference hall or laboratory, we seem best able to tackle the social and psychological only when we have solved the physical first”. This could be interpreted as meaning that in the clinic, Wessely School adherents (ie. proponents of the biopsychosocial paradigm of disease) will continue to patronise ME sufferers by assuring them that their symptoms really are “physical” in order to get their trust, whilst in the conference hall and laboratory (where the “real” issues are addressed), the social and psychological will continue to be the key issues.

From the Discussion after Professor Kate Lorig's presentation (chapter 12: "What are the barriers to healthcare systems using a biopsychosocial approach and how might they be overcome?")

Professor Kate Lorig from the Stanford Patient Education Research Centre at Stanford School of Medicine provided some telling answers. When asked by Professor Mansel Aylward how did she recruit people into the biopsychosocial model, she replied: "I'd put real marketing experts onto it. The programme is now being used in about 14 countries and the Australians found out that the way to recruit is via symptoms. Are they tired? If so, come along. We have been running the same programme with monolingual Spanish speakers. We run it in churches and community halls. This past Easter I went to mass twice, and I'm Jewish. The place to find Spanish speakers in the USA is mass on Easter Sunday. Between myself and the staff we covered 17 masses. We just take their names and addresses and then call them later. The system has to go to them, you don't ask them to go to the system. We have not focused on diseases, but on symptoms. This is what they respond to".

Peter White then asked Professor Lorig: "Have you seen a differential effect in outcome by diagnosis or diagnostic group? I ask this because work done in the UK under the aegis of the Department of Health suggested that a particular diagnostic group, chronic fatigue syndrome, did not do at all well (but that) patients with CFS did better when they did the programme with patients with arthritis". Lorig replied that they were currently doing studies to see whether it makes much difference if people are in a disease-specific group, but that their initial results did not show a great deal of difference.

Professor Francis Creed asked Lorig: "We were discussing some of the organizational barriers to instituting the biopsychosocial model more widely (but) it sounds like you have been very successful in overcoming them. What are the most telling things that have made a difference?", to which Lorig replied: "We have proselytised....the 'innovators' leap out in front and try everything new. These were not the people we want to reach. Instead, we wanted to target the next group, the 'early adopters' (of the regime). These are the people that need to be successful. If they are, the rest of the world will eventually come along".

Professor Michael von Korff (Senior Investigator from the Centre for Health Studies in Seattle) then said: "Kate Lorig outlined sources of resistance. If we want to make the biopsychosocial model work, we need to start addressing some different fields than the primary care visit and medical care".

Mike Fitzpatrick said: "It is interesting to contrast the approach Kate Lorig is talking about with what we are familiar with about patient campaigns, which often have a very activist feel to them, such as the ME campaign. There are vast numbers of these self-help groups. What Kate has described has a strongly top-down character (and) the nature of the training seems didactic, with master trainers. How does this sit with the existing self-help campaigns?"

Lorig replied: "The two master trainers in the UK both came from patient groups.....we have had virtually no resistance from patient groups".

Wessely asked: "What would happen if (a) group started to challenge these particular treatment ideologies and said they wanted to know how to get more benefits from the state? You are going to come to some bits where some people in the room might say 'I tried that

and it didn't work for me: in fact it made me worse' ", to which Lorig's reply was: "I'd say, ' You know, then I really think you shouldn't do it' ".

Trudie Chalder said to Kate Lorig: "It is clear that you are a very effective cognitive behavioural psychotherapist and I want to congratulate you on your programme. It sounds marvellous". Lorig replied: "If you are interested in it, I would suggest seeing it in action. Bob Lewin has done this".

Professor Robert Lewin (from the Department of Health Sciences at the University of York) said: "I went along because I got involved through the Department of Health. They wanted some disease-specific modules. I thought this was going to be done by people who had been taught by rote how to do this from a set of flip charts. Goal setting is completely different when it is done by lay people. I had to be careful as a fairly experienced therapist to forget the part of me that wanted to guide the process. I wonder if patient-generated goals last longer. As we all know, CBT gains tend to fade over time".

Wessely said: "My immediate reaction is to wonder about the slightly false dichotomy you set up between orthodox and alternative medicine. I am extremely sceptical about complementary medicine. The question you address is whether the biopsychosocial model is the same as the model of alternative medicine. I am absolutely certain it can't possibly be, or otherwise I wouldn't so criticize it. In the field we work in, the alternative views on chronic fatigue syndrome are unbelievably reductionist. There is a group of people who consult alternative practitioners because they want the most biological explanations about allergies and so on. They see them in a political framework: it's all the fault of governments and industry. In those models there is no room for any psychosocial element".

Mansel Aylward said: "Today we have hit on what I think are the crucial issues. These aspects of the biopsychosocial model have had the greatest impact in developing social and welfare policy in the UK. These techniques are simply described and one can communicate them to our colleagues, and even to our politicians, who sometime find it difficult to grasp these issues. This sort of work will strongly influence how social policy and rehabilitation will develop over the next year or so. Importantly, we should consider the work by Buchbinder in Australia. This showed the utility of a multi-media educational programme. We hope we will be able to repeat some of this here".

Michael Von Korff said: "If you take interventions that individually are modest in their effects and you have the healthcare system and the social welfare system using these approaches consistently, you end up with a larger effect. This is a very important aspect".

Peter White said: "There are two ways to change beliefs. You can change beliefs first using cognitive behavioural therapy, which leads to behaviour changes (or you can) change the behaviour first, which then changes the cognition. Exposure is needed to the particularly avoided behaviour, which is exercise or physical activity in chronic fatigue syndrome. Perhaps we need to look carefully at how an intervention programme is delivered for each disease".

Robert Lewin observed: "You may have delivered the exercise programme in a far more psychological way, but purely physical exercise programmes do not have very much effect".

Wessely said: "We are talking about barriers. The people we see just don't believe us".

Michael Von Korff said: “If we start with the assumption that all chronic pain patients are motivated largely by secondary gain and are difficult and demanding individuals, then we will miss the broader opportunity to fundamentally change the way (such patients) are managed in the healthcare and social welfare systems”.

Kate Lorig said: “This is where we have to develop key messages, which the healthcare system gives consistently”.

Simon Wessely said: “We accept that. This is what we do in treatment programmes. But we also know that even getting patients to see us is a challenge because of their fear-avoidance beliefs”.

Michael Sharpe said: “I’d like to get the word iatrogenesis on the table; doctors do cause harm by their psychological interventions: people often do not get consistent messages from their various medical attendants. In fact, in the UK at least, there are substantial numbers of doctors who give people exactly the opposite advice in terms of this evidence. When Simon Wessely is trying to tell his patients one thing, they can read something entirely different on the internet or see someone else who will tell him or her exactly the opposite. That inconsistency of apparently authoritative information is an important part of the problem”.

Peter White said: “The biopsychosocial approach is import in addressing disability associated with all chronic ill-health, whatever its provenance (but) there is an overwhelming amount of evidence for the utility of the biopsychosocial approach in both understanding and helping patients with mental ill-health and physical symptoms for which no explanation is apparent. The latter includes common disorders such as chronic fatigue syndrome. How can barriers to making the biopsychosocial approach routine for chronic ill-health be removed? Barriers to implementing this approach exist within patients, professionals, and health-care systems. Health-care systems will routinely incorporate the biopsychosocial approach when convinced of its economic advantages. But a more convincing case may mean considering economic costs across the whole of society, not just the health-care system”.

Discussing professional education and training in relation to the biopsychosocial approach, White said: “Teaching the skills necessary for professionals to feel confident that they can address the problems thrown up by a biopsychosocial approach is more important than persuading them to ask the appropriate questions”.

White went on: “Because many patients now use the internet for information on their health, we should make greater use of this medium to get the right message across”.

He then said: “Above all, patients need to know that the biopsychosocial approach is simply an extension of the biomedical approach (and) because patients, health-care systems, and benefits providers have most to gain, it is probably they who will drive the agenda forward, unless we take the lead ourselves”.

The one dissenting voice at the conference was that of George Davey Smith, Professor of Clinical Epidemiology, Department of Social Medicine, University of Bristol, who in a presentation called “The biopsychosocial approach: a note of caution” carried the torch for intellectual integrity. His contribution showed that bias can generate spurious findings and that when interventional studies to examine the efficacy of a psychosocial approach have been used, the results have been disappointing.



To quote from Davey Smith's contribution: "Over the past 50 years many psychosocial factors have been proposed and accepted as important aetiological agents for particular diseases and then they have quietly been dropped from consideration and discussion". The illustrations he cited included cholera, pellagra, asthma and peptic ulcer. He went on to quote Susan Sontag's well-known dictum: "Theories that diseases are caused by mental state and can be cured by willpower are always an index of how much is not understood about the physical basis of the disease" (Illness as a metaphor. New York: Random House; 1978).

Davey Smith's reasoned warning brought to mind the validity of Susan Haack's chapter "Concern for Truth: What it means, Why it matters" in "The Flight from Science and Reason". (Eds) Paul R Gross, Norman Levitt and Martin W Lewis (New York Academy of Sciences, 1996; pp57-63), which finds that those who know only their own side of a case know very little of that, and that "sham reasoning" attempts not to get to the truth, but to make a case for the truth of some proposition to which one is already committed, a familiar phenomenon in contemporary academic life. "Sham reasoning" in the form of research bought and paid for by bodies with an interest in its turning out in a desired way, or motivated by political conviction, and "fake reasoning", in the form of 'scholarship' that is in reality self-promotion, are all too common. Could this possibly apply to members of One-Health company?

In the discussion that followed Davey Smith's presentation, Wessely appeared to be apoplectic: "That was a powerful and uncomfortable paper. There will undoubtedly be many people, including those who one might call CFS activists, who would have loved every word you were saying. There is a popular and seductive view of medical history in which we move implicitly from unknown diseases which are thought to be psychiatric, and as we become better, brighter scientists, they are finally accepted in the pantheon of real diseases. You should remember that there is an opposite trend as well, which you didn't mention".

Davey Smith's response was succinct: he believed there is a need to distinguish association from actual causation: "My main point was about disease aetiology. As a disease epidemiologist I want to get the right answers about this. In my view, susceptibility has been overplayed and exposure has been under-appreciated in social epidemiology".

The distinguishing between association and causation is a key issue: Wessely's confusion, especially in relation to ME/CFS, of association with causality is a criticism that has long been directed at him and he has been reminded again and again that correlation is not the same as causation, and that he should not over-interpret results as having more practical importance than those results warrant. To do so is not only methodologically flawed, but contributes to the continued mis-perception of the disorder.

Nevertheless, and perhaps unsurprisingly, Professor Sir Michael Marmot sprang to support Wessely: "I would emphasize Simon Wessely's point. It is easy to look back and say, 'Gosh, how silly they were in the past to think all these silly thoughts; aren't we clever now!'. Research has advanced beyond the examples you cite because there have been many advances in conceptualisation and measurement of psychosocial factors", to which Davey Smith replied: "We can get more robust evidence from observational studies, but these approaches have not really been utilized in the psychosocial field".

Illuminating as these extracts have been, it is the final discussion ("How to overcome the barriers") that strikes the most chilling resonance because it seems to embody the social

construction of their own version of reality by these influential and determined social constructivists: this is alarming because there are parallels in comparatively recent history that are forgotten at humanity's peril.

In the final discussion, Peter White thought it would be useful to outline the barriers identified in their discussion and to explore ways round those barriers. He said: "I think we have agreed that the aetiological work is not immediately relevant to the biopsychosocial model in the healthcare system at the moment. Therefore what we need to concentrate on pragmatically is the use of the biopsychosocial model in healthcare".

This would seem to be the clearest indication that the causation (and thus the accurate nature) of disease is of no relevance to One-Health social constructionists.

Douglas Drossman (Professor of Medicine and Psychiatry, University of North Carolina, USA) said: Is there a way to communicate these ideas to the people involved with running medical schools? Often, the problem is in changing the behaviours of physicians at practice who are 50 years old. It may be much easier to start with new medical students. We want to begin with them".

At this point, Trudie Chalder made a truly disturbing contribution: "Rather than start with the physicians, which might be quite a difficult task, we could make a start with youngster in schools. My experience is that they are much easier to educate. The only barrier is the parents. Once we have the child on our side we are in a very good position".

Kate Lorig then said: "I'd like to suggest something a little more radical. I think we need some *patients* to look at how healthcare is delivered. It would be easy to put the biopsychosocial model into this setting".

Wessely said: "Mansel Aylward, you are involved with policy definitions. What have you heard here that might influence your Secretary of State?"

Aylward said: "I have been given a lot of information that reinforces some of the messages that I have passed on to decision makers. We had some great difficulty last year persuading certain people that the way forward in the more effective assessment of disability and its management in people on State benefits lay more with a biopsychosocial approach. There seems to be an antipathy in some parts of Government towards anything without a hard evidence base. If the biopsychosocial approach is perceived in (such a) way, it is very difficult to get the Department of Health, amongst others in Government, to favour interventions and rehabilitation adopting the biopsychosocial approach. But in recent months I'm beginning to see a change".

Wessely: "What made some of the policy makers change their views?"

Aylward: "Systematic reviews of the literature garnering evidence to support the biopsychosocial concept. Recent meetings of focus groups of key opinion makers (now) support ---with authoritative and expert opinion --- the value of biopsychosocial approaches. There are going to be some developments soon. The key aspect has been effectively communicating this in a far more robust and authoritative way".

It is noted here that Aylward used the words expert "opinion", not expert "evidence".

Professor Gordon Waddell (Centre for Psychosocial and Disability Research, Cardiff) said: “It may actually be easier to change patients and the public, and they will then force the professionals to change. Some decision makers were very jaundiced. It is all about money. The main thing was to persuade the Treasury that there was an opportunity for keeping costs down”.

Professor Robert Lewin said: “One of the things that Greville Mitchell is helping us do through One-Health is an analysis that will look at the lost opportunity costs from not using cognitive behavioural therapy approaches. We are doing this in collaboration with Jos Kleijnen”.

Greville Mitchell said: “If you go to Gordon Brown (UK Chancellor of the Exchequer) and say, ‘We can prove to you that if we address this issue, we can save £2 billion, then you have his full attention”.

Mansel Aylward said: “That is the approach that has been taken”.

Helge Malmgren, Professor of Theoretical Philosophy, Goteborg University, Sweden, said: “Considering that so many people go to alternative and complementary medicine practitioners, perhaps we should not only confront alternative medicine, but also try to make alliances. In particular, we could try this with practitioners who use brands of alternative medicine that we think have some plausibility”.

Wessely said: “In many levels this is happening. We discussed whether we should call this business ‘integrated healthcare’. Unfortunately, Prince Charles has taken this name”.

Dr Brian Marien of the Health Psychology Unit, King Edward VII Hospital, Midhurst, West Sussex, said: “I like Gordon (Waddell’s) idea of changing patients, because I don’t think we are going to change the professions. We have seen from Kate Lorig how there is a huge resistance to changing practice”.

Mike Fitzpatrick said: “The line from the ME Association is that if you, as a GP, say you are sceptical about the ME label, the Chief Medical Officer has stipulated how this must be dealt with. This reflects the endorsement at the highest level of policy of a disease label that is not supported by the evidence --- it is a completely irrational formulation”.

Mansel Aylward’s response was: “It doesn’t follow that all of that report is supported by everyone in Government service. The Department of Work and Pensions doesn’t necessarily endorse all that is in the Working Party’s report to the Chief Medical Officer. I am also mindful of the views of those who, as members of that group, distanced themselves from some aspects of the report”.

Fitzpatrick said: “Nonetheless, this is the line and it is very much promulgated that GPs should follow this. It is a consensus forged by excluding many of the people in this room who have been involved in this area. This illustrates a big problem: the Government are linking up with patient activist groups in relation to this very significant area of medical practice to dictate a line of approach which is not actually going to be beneficial to patients”.

Wessely’s reply was: “This is a problem that would need five separate conferences to address”.

Professor Michael von Korff said: “If this (biopsychosocial) field doesn’t start to do definitive trials and strengthening of the research base, we are dead in the long run”, to which Wessely replied: “There is no dispute about that. Some of the evidence doesn’t translate into policy as quickly as we would like, but without evidence, I am quite sure that there would be no changes. Evidence alone is not enough”.

Wessely then said to Greville Mitchell: “I think you should have the last word”.

Greville Mitchell said: “The question in the title of this meeting was whether the biopsychosocial model is a necessity or a luxury. To me, the answer from this meeting is that it is clearly a necessity. It has been a brilliant meeting”.

It may have been a “brilliant” meeting as far as most of the participants were concerned but a glaring question remains unanswered: during the meeting, Professor Robert Lewin from the Department of Health Sciences at York stated: “As we all know, cognitive behavioural therapy gains tend to fade over time”; this being so (and quite apart from any consideration of the appropriateness or efficacy of CBT from the outset), how can the psychosocial model that depends on CBT be sold as being so attractive to the Chancellor of the Exchequer? Is the Chancellor being deceived about the “lost opportunity costs from not using the cognitive behavioural therapy approaches”? If CBT has no lasting benefit, how can it be cost-effective? Is this self-delusion on the part of One-Health company members?

A further point that seems to remain unaddressed relates to Peter White’s claim that the biopsychosocial model is “simply an extension of the biomedical model”. This claim is not supported by the published views of One-Health company members, who without question have denied the validity of the biomedical model specifically in relation to ME/CFS and have sought to substitute their own biopsychosocial model, not to use it as an adjunct. If the biopsychosocial approach worked in cases of authentic ME, patients would be clamouring for it, not refusing it, but it clearly does not work in ME/CFS and graded exercise may even be life-threatening for the most severely affected. As Wessely himself said: “The people we see just don’t believe us”.

Is it not a little ironic that Mike Sharpe voiced his concern about iatrogenesis: “doctors do cause harm by their psychological interventions” (presumably he is referring to non-psychiatrists) without apparently being able to comprehend the iatrogenesis inflicted upon those with ME/CFS by him and his colleagues through their own psychological interventions?

In essence, the meeting seems to have exemplified an exercise in self-promotion rather than an enlightening exercise.

Overall, the meeting seems to have crystallised One-Health company members’ clear intention to exert an unchallenged stranglehold over defenceless sick people who suffer from what One-Health company members deem to be “medically unexplained symptoms”, in that the best interests of such sufferers are to be sacrificed on the pecuniary altar of the State.

Indeed, there is now hard evidence that a cabal of social constructionists are bent on indoctrinating politicians and Government agencies worldwide – and in the UK are not averse to publicly side-lining even the Chief Medical Officer – and on imposing their own ideology onto an unwitting public and an unconvinced medical profession. This is to be done

by means of programmed brain-washing that the cabal intends to be implemented not only by the Government agencies they have groomed but also by multi-media “educational” campaigns as well as by using the internet, starting with the indoctrination of children at school (ie. before their critical faculties are sufficiently developed to enable them to be discriminating, which seems particularly morally repugnant).

Such determination to change people’s beliefs may result not only in the removal of a person’s right to receive appropriate medical care but may further distort the social structure of what was once a decent British society in which respect was afforded to the sick as of right, because the nature of the State seems to be being changed by social constructionists from democracy to autocracy (ie. tyrannical control of the individual).

Such behaviour is not dissimilar to that of a cult, whose members in this case have a great deal invested in their own beliefs.

However, by seeking to impose their cult ideology, this group has probably done more than most to prolong the artificial mind-body dualism they claim to despise, because people will see them for what they are –self-promotionists par excellence.

In her review of “Biopsychosocial Medicine”, US research journalist Kate Duprey hits the nail exactly on the head: “For the past two decades medicine has been engulfed in an ideological firestorm that is less about actual patients and their well-being than it is about professional promotion and a backlash against a medical model that does not give psychiatrists a starring role in healthcare. This book gives a good overview of the thinking on one side of the raging battle (but) I didn’t find it to be balanced. How such polarization is helpful to patients is not adequately addressed, possibly because the well-being of patients is not the real focus. When something is controversial, balance is presenting both sides, yet little or no attention was given to the large bodies of scientific research objectively refuting the stated views of the contributors. (The book) essentially remains a book of self-promotion”

(see Controversial for a reason. August 5, 2005,  
[http://www.amazon.com/exec/obidos/tg/detail/-/0198530331/qid=1125670603/sr=8-2/ref=sr\\_8\\_xs\\_ap\\_i2\\_xgl14/103-3052351-3936630?v=glance&s=books&n=507846](http://www.amazon.com/exec/obidos/tg/detail/-/0198530331/qid=1125670603/sr=8-2/ref=sr_8_xs_ap_i2_xgl14/103-3052351-3936630?v=glance&s=books&n=507846) ).

It was also interesting to read the review of “Biopsychosocial Medicine” by Aziz Sheikh in the current Journal of the Royal Society of Medicine, where it was promoted as book of the month (JRSM 2005:98:431-432), because Sheikh summed it up thus: “How does “Biopsychosocial Medicine” move the subject on? Despite valiant attempts by Simon Wessely and Peter White to draw practical messages, I have to say not greatly”.

It may not have moved the subject on but it has done nothing to provide those who suffer from the savage disease ME/CFS with even a modicum of hope.

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**4th September 2005**

More Proof Positive?

Eileen Marshall and Margaret Williams

[View](#)

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