Memorandum to the Health Select Committee to assist its Inquiry into the work of the National Institute for Health and Clinical Excellence (NICE)

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1. Introduction

1.1 This memorandum relates to the work of NICE in one specific area, namely its Guideline on the management of adults and children with Chronic Fatigue Syndrome / Myalgic Encephalomyelitis ("CFS/ME") currently in preparation, a draft of which was issued on 29th September 2006.

1.2 It is submitted by Malcolm Hooper, Professor Emeritus of Medicinal Chemistry at the University of Sunderland, in conjunction with Eileen Marshall and Margaret Williams – an established team whose aim is to expose and prevent the injustice perpetrated on patients with ME/CFS in the UK by those whose job is to help, not abuse, such patients. Both Eileen Marshall and Margaret Williams formerly held senior clinical posts in the NHS. "Margaret Williams" is the professional name used by her for the last 13 years; the Duty Clerk has confirmed that the use of a professional name by which a person is known is perfectly acceptable to Members.

1.3 Contact address: Professor M Hooper, 2 Nursery Close, Sunderland, SR3 1PA. Telephone number: 0191-528-5536.

1.4 Short Curriculum Vitae of Professor Hooper:

- B Pharm. degree from the Faculty of Medicine, University of London, 1956.
- PhD from the Faculty of Medicine, University of London, 1959.
- Appointed Lecturer in Pharmaceutical and Medicinal Chemistry in 1959 and then Reader in 1969.
- Appointed Professor of Pharmaceutical and Medicinal Chemistry, March 1982.
- Taught students of pharmacy, pharmacology and pharmaceutical and chemical analysis at honours degree level.
- Directed research at Masters and Doctoral level, supervising PhD students.
- Served as an examiner in UK universities at graduate and postgraduate level; has also served as examiner at universities in India and Tanzania.
- Has published some 50 papers in peer-reviewed journals in the field of medicinal chemistry and has edited a book on medicinal chemistry.
- Acted as referee for a number of scientific journals and has served on an editorial Board.

- Served on Committee of the Council for National Academic Awards and also of the World Health Organisation.
- Is a member of a number of learned societies, including the Royal Chemical Society and the British Pharmacological Society. For over 12 years he was on the committee of the Society for Medicines Research and served as Chairman for two years; this involved the planning and organising of major national and international conferences.
- Appointed Chief Scientific Adviser to the Gulf Veterans Association and has submitted evidence to the Select Committee on Defence - also serves on the Gulf Support Group convened by the Royal British Legion.
- For a copy of Professor Hooper's full CV contact him directly at malcolm.hooper@virgin.net

2. Important Background Information

2.1 Terminology is confusing but important: the term "ME/CFS" reflects the two interchangeable terms (myalgic encephalomyelitis and chronic fatigue syndrome) that are listed in the World Health Organisation's International Classification of Diseases where, since 1969, ME has been classified as a neurological (ie. an "organic") disorder. However, certain UK psychiatrists and the Government bodies they advise use the term "CFS/ME"; on their own admission, they do so merely to placate patients by retaining the term "ME". Their recorded intention is to eradicate "ME" and to re-classify "CFS" as neurasthenia (a mental disorder). This has serious ramifications for patients, since mental disorders receive lower rates of State sickness benefits and are excluded from medical insurance cover.

2.2 The incidence of ME/CFS is rising alarmingly. In order of insurance costs, one of the major medical insurance companies (UNUM Provident) reported in 1993 that ME/CFS came second in the list of the five most expensive chronic conditions, being three places above AIDS. In August 2004 the same company issued a Press Release reporting a 4,000% (four thousand) increase in claims for symptom-based syndromes, including ME/CFS. No other disease category surpassed these rates of increase. UNUM's "CFS Management Plan" states: "*UNUM stands to lose millions if we do not move quickly to address this increasing problem*". The latest estimate (January 2007) of the economic impact of ME/CFS in the US is between $22 / $28.6 billion annually; in Japan it is $10 billion annually.

2.3 Significant published evidence supports the tenet that ME/CFS is an inflammatory autoimmune disorder that progresses to a complex multi-system neuro-endocrine-immuno-microvascular disorder with cardiac involvement. It devastates the lives not only of patients themselves but also of their families. For a short summary of the 8th International (ME)CFS Clinical and Research Conference held in Ft Lauderdale, Florida in January 2007 – at which yet more evidence was presented that comprehensively destroys the psychiatric paradigm so tenaciously adopted by NICE

and the UK Medical Research Council -- see www.meactionuk.org.uk/Facts_from_Florida.htm .

3. Executive Summary

3.1 In defiance of the substantial biomedical evidence submitted to its Guideline Development Group (GDG), NICE is recommending an inappropriate and potentially dangerous behavioural modification regime as the only management strategy for those with ME/CFS.

3.2 NICE's recommended management regime is promoted by a group (mainly psychiatrists) who have undeclared but undeniable competing financial interests. Their influence has resulted in a biased and unrepresentative consideration of the international peer-reviewed evidence upon which NICE is relying to support its national Guideline that purports to be "evidence-based" when it is nothing of the sort.

3.3 The evidence here submitted draws attention to the intentionally selective advice that NICE receives from its chosen advisors, who for almost two decades (ie. before NICE was set up in 1999) have dismissed and/or ignored the biomedical evidence that is germane to the issues under consideration.

3.4 NICE maintains that its recommended psychotherapy regime is also promoted in its Guidelines for other organic diseases. This is untrue. This proposed Guideline for "CFS/ME" seems to be unique: in none of a sample of 12 existing Guidelines for organic disorders does NICE propose psychotherapy as the treatment of choice – it is only in the case of ME/CFS that cognitive behavioural therapy and compulsory graded exercise therapy (CBT/GET) is proposed as a specific treatment. If, on medical advice, patients refuse – or are simply too sick to participate in – this regime, their State and medical insurance benefits are already being withdrawn and some patients face destitution. Facing insuperable odds, a significant number of ME/CFS patients have committed suicide.

3.5 In the case of ME/CFS, NICE has failed to comply with the AGREE (Appraisal of Guidelines Research and Evaluation) Instrument to which it is party.

4. First term of reference: Why NICE's decisions are increasingly being challenged

4.1 The alleged "independence" of NICE: NICE was set up – and is funded – by the Department of Health, to which it remains accountable. A common perception is that NICE is far from "independent" and that its raison d'etre is to provide a shield for Government and Ministers who seek to preserve an untarnished reputation when unpalatable cost decisions have to be made, and who can then reassure the electorate that they are relying on ostensibly "independent" advice.

4.2 The evidence on which NICE has relied for the production of its "CFS/ME" Guideline has been provided by a small and unrepresentative group of self-styled "experts" and their adherents who study a heterogeneous patient population, resulting in flawed conclusions: Within their own discipline, Wessely School psychiatrists are regarded as mavericks. They are known colloquially as the "Wessely School" after their prime mover Professor Simon Wessely of Kings College Hospital and the Institute of Psychiatry (ref: *Hansard [Lords] 19th December 1998:1013*). Key members are Professors Michael Sharpe, now at Edinburgh, and Peter White of St Bartholomew's, London (who holds the "CFS/ME" reins at the Department for Work and Pensions, whose own forthcoming DWP Guidance about "CFS/ME" has been rejected as unfit for purpose by a coalition of ME charities). The work of the Wessely School on "CFS/ME" has been stringently criticised in the international literature for flawed methodology; for use of a heterogeneous patient population (studies using mixed populations are not useful unless researchers disaggregate their findings); for selective manipulation of others' work, claiming it supports their own findings when such is not the case; for their focus on the single symptom of "fatigue" whilst ignoring other significant signs and symptoms associated with the cardiovascular, respiratory, neurological and immunological systems; for generating conclusions before generating the data to support such conclusions; for advising Government bodies that the reported biomedical abnormalities "*should not deflect the clinician away from the biopsychosocial approach and should not focus attention towards a search for an 'organic' cause",* and for their recommendation that no advanced tests should be carried out on "CFS/ME" patients when it is those very tests that reveal the unequivocally organic nature of the disorder. It is only when dealing with "CFS/ME" that these psychiatrists are regarded by Government bodies and the medical insurance industry as "experts". These psychiatrists are on record as being actively involved in social engineering via the deliberate creation of "psychosocial" illness. They believe that the biomedical approach to healthcare (ie. that ill-health and disability is directly caused by disease and its pathological processes) is (quote) "*a blind alley*" and that the correct approach is the psychosocial one, in which "aberrant" thoughts, feelings and behaviour can be "modified" by their own brand of cognitive behavioural therapy with graded exercise (CBT/GET), resulting in restoration of health and productivity. Such a retrograde belief is fallacious, as the regime in question has been shown to be ineffective, yet NICE ignores the evidence submitted to it showing that even the proponents of its recommended regime are themselves on record as acknowledging that (i) it is not remotely curative (ii) modest gains may be transient and even illusory (iii) these interventions are not the answer to ME/CFS (iv) patients have a tendency to relapse and (v) evidence from randomised trials bears no guarantee for treatment success (ref: www.meactionuk.org.uk/Concerns_re_NICE_Draft.pdf). For a detailed review of Wessely School indoctrination of State agencies, and the impact of this on social and welfare policy, see www.meactionuk.org.uk/Proof_Positive.htm .

4.3 NICE has limited itself to -- and based its recommendations for the management of "CFS/ME" on -- a flawed 2005 Systematic Review from the Centre for Reviews and Dissemination at York, whose lead author was persuaded to change her mind between her 2001 article in the Journal of the American Medical Association (JAMA) and her 2005 Review for NICE: This may amount to scientific misconduct since the same author has remarkably different approaches to the same data in the two documents concerning the recommended psychiatric management regime favoured by NICE (CBT/GET). In 2001, she found methodological inadequacy; study withdrawals with high drop-out rates; unacceptability to patients of the regime in question; the exclusion of severely affected patients from all studies; the reported improvements of the management regime may be illusory, with little lasting benefit, and an acknowledgement that the data had been corrupted. These findings were published in one of the world's most prestigious medical journals (JAMA), yet in her York Review for NICE, the same author disowns her own previous findings on exactly the same data; she excludes the many reports of adverse events and signally fails to address the safety and effectiveness of the recommended interventions (a remit with which she was specifically charged). A possible explanation for this *volte-face* is that the advisers to the non-medical York Review Team who prepared the Review for NICE were prominent members of the "Wessely School" (ie. advisors to Government Departments, including the Medical Research Council, and the medical insurance industry). For an analysis by Hooper and Reid of the 2005 York Systematic Review upon which NICE is relying, see www.meactionuk.org.uk/FINAL_on_NICE_for_Gibson.html .

4.4 The advisors upon whom NICE relies have been shown to have undeclared vested interests: These psychiatrists and their adherents are heavily involved with the medical insurance industry, including UNUM Provident, Swiss Life, Canada Life, Norwich Union, Allied Dunbar, Sun Alliance, Skandia, Zurich Life and Permanent Insurance, as well as the re-insurers Swiss Re, at which Peter White is Chief Medical Officer. For the way in which these psychiatrists deal with ME/CFS claims, see www.meactionuk.org.uk/Notes_on_the_Insurance_issue_in_ME.htm. For an exposition of their commercial conflicts of interest in relation to the Department of Work and Pensions, see www.meactionuk.org.uk/Obs_on_DLA_Handbook_for_Gibson.html. Wessely is further involved with PRISMA, a multi-national health-care company working for insurance companies. In its company information, Wessely is listed as a Corporate Officer; he is a member of the Supervisory Board and in order of seniority he is higher than the Board of Management (for more information, see www.meactionuk.org.uk/What_Is_ME_What_Is_CFS.htm). A recent Report, known as the Gibson Report, by a group of Parliamentarians (including Dr Richard Taylor, who is also a member of the Health Select Committee) states: "*There have been numerous cases where advisors to the DWP have also had consultancy roles in medical insurance companies. Given the vested interests medical insurance companies have in ensuring CFS/ME remains classified as a psychosocial illness, there is a blatant conflict of interest here. The Group finds this to be an area for*

serious concern and recommends a full investigation by the appropriate standards body" (For a summary of the Report findings, see www.meactionuk.org.uk/Summary_of_Key_Points_in_Gibson_Inquiry_report.htm). It is a matter of concern that NICE's chosen advisers on its "CFS/ME" Guideline Development Group include Dr William Hamilton, who has a published track record of believing "CFS/ME" to be a behavioural disorder. Moreover, he has spent 15 years working for the medical insurance industry and is currently Chief Medical Officer for a major medical insurance company, the Exeter Friendly Society. It was he who drew up the company policy that specifically excludes those with "CFS/ME" from eligibility for sickness benefit. Another member of NICE's GDG is psychologist Dr Hazel O'Dowd who also subscribes to the "behavioural disorder" model. However, she has recently published a paper that ought to cause NICE to reconsider its recommendations, as it showed that group CBT did not bring about the anticipated improvements. Another NICE GDG member is Dr Fred Nye, who was forced to make a public apology after his Department issued an advertisement for therapists informing applicants that "CFS" patients have "perpetuating illness behaviour"; that they experience "barriers to understanding" and that therapists will be required to "modify patients' predisposing personality style". Had such attributions been ascribed to those with multiple sclerosis, there would have been a national outcry. For an analysis of legitimate concerns about the NICE draft Guideline on "CFS/ME", see www.meactionuk.org.uk/Concerns_re_NICE_Draft.pdf .

4.5 NICE's advisors have an indisputable track record of denigrating patients with "CFS/ME": Members of the "Wessely School" have a long track record of denigrating patients with ME. See, for example, "Denigration by Design?" at http://25megroup.org/denigration%20by%20design/denigration%201.htm and also "The Mental Health Movement: Persecution of Patients?" by Hooper et al at www.meactionuk.org.uk/Select_CTTEE_FINAL_VERSION.htm. This includes in Appendices I and II a selection of quotations from the published works on patients with "CFS/ME" of Professors Wessely and Sharpe respectively, so Select Committee members can judge this denigration for themselves. The "Wessely School" – and now NICE itself -- dismisses and / or ignores the substantial body of international scientific evidence which comprehensively proves them to be wrong in their assertions that "CFS/ME" is primary mental disorder (see, for example, the 174 page document "Illustrations of Clinical Observations and International Research Findings from 1955 to 2005 that demonstrate the organic aetiology of ME/CFS" by Hooper, Marshall and Williams at www.meactionuk.org.uk/Organic_evidence_for_Gibson.htm. See also the document "ME exists: True or False?" at www.meactionuk.org.uk/ME_Exists_-_True_or_False.htm). It is beyond reason that so many documented physical abnormalities in people with ME/CFS should simply be disregarded and/or denied and ascribed to a "behavioural" disorder by NICE, including the following: abnormalities of the central nervous system, of the autonomic and peripheral nervous systems, of the cardiovascular, respiratory and immune systems; evidence of muscle

pathology; neuroendocrine abnormalities; defects in gene expression profiling; abnormalities in HLA antigen expression; evidence of persistent virus activity, with abnormalities in the 2-5 synthetase / RNase-L antiviral pathway; disturbances in oxidative stress levels; gastro-intestinal, reproductive and visual dysfunction, all of which are dismissed – and even actively suppressed in the UK -- by Wessely School psychiatrists in their advice to Government bodies, and to NICE.

4.6 The evidence about "CFS/ME" upon which NICE relies has been proven to be biased in favour of current Government policy to create nationwide centres for psychotherapy: It is well-known that, on the advice of Lord Layard, in order to remove people from Incapacity Benefit, Government favours cognitive behavioural therapy for all chronic ills. This is borne out by the negative stance taken by the MRC when considering research applications into the organic aetiology of ME/CFS -- documentary evidence exists showing that the MRC internally classifies "CFS/ME" as a mental (behavioural) disorder; by NHS Plus in its published Policy Document of October 2006 ("Occupational Aspects of the Management of CFS: a National Guideline" [DH publication 2735539], whose external advisors were psychiatrists Professors Michael Sharpe and Peter White), and by NICE's own entrenched position about its preferred management regime, namely behavioural therapy, which has already been promoted and disseminated throughout the NHS as "*effective treatment for CFS*" in its "Effective Health Care" Bulletin of 23rd May 2002 by the York Centre for Reviews and Dissemination. Given the existing extensive implementation of this policy and the relentless dissemination of its alleged efficacy by its proponents (for example, the assiduous advertising of a lecture at the Institute of Psychiatry on 28th February 2007 by Professor Trudie Chalder – a staunch advocate of the behavioural model of ME/CFS who works with Simon Wessely -- promoting NICE's advocacy of behavioural and exercise "therapy" for ME/CFS), unless legally compelled to change direction in line with the international evidence that has been so effectively downplayed by its advisors, NICE is unlikely to do so. This would be to the serious detriment of between 120,000 and 240,000 very sick people in the UK (figures given in the Chief Medical Officer's Report of 2002), which is a prevalence five times that of HIV/AIDS. For comparison, there are about 83,000 people in the UK who suffer from multiple sclerosis. According to the US Centres for Disease Control, four million Americans have ME/CFS (see http://listserv.nodak.edu/cgi-bin/wa.exe?A2=ind0701d&L=co-cure&T=0&P=5201), which is more than those who suffer from multiple sclerosis, lupus, lung cancer and ovarian cancer combined. In the US, lung cancer alone has a prevalence of 350,000 (ie. about half that of ME/CFS).

4.7 NICE fails to adhere to its own terms of reference: NICE is a party to the Appraisal of Guidelines Research and Evaluation Instrument (the AGREE Instrument) so is obliged to conform to certain standards in the production of its Guidelines, which in the case of this Draft "CFS/ME" Guideline it has signally failed to do. The NICE Guidelines are intended to be "*systematically developed statements to assist*

practitioner and patient decisions about appropriate healthcare for specific clinical circumstances". Their purpose is *"to make explicit recommendations with a definite intent to influence what clinicians do"*. Because the intent is to influence what clinicians do (which immediately impacts on patients), there are rigorous criteria (currently 23) which policy makers and Guideline developers must observe in the production of a Guideline. The most important criteria in relation to the Draft Guideline on "CFS/ME" are:

- **There should be an explicit statement that all group members have declared whether they have any conflicts of interest:** there is no evidence in the Draft Guideline that GDG member Dr William Hamilton has made any such declaration

- **The patients to whom the Guideline is meant to apply should be specifically described**: the Draft Guideline fails this criterion as there is no such disorder as "CFS/ME": the Wessely School believe that "CFS" is synonymous with neurasthenia, which is a classified mental disorder at ICD-10 F48, but ME/CFS is a classified neurological disorder at ICD-10 G93.3 and fibromyalgia is a classified soft tissue disorder at ICD-10 M79; to lump these different disorders together as one single disorder (as the MRC does in its on-going "CFS" trials led by Wessely School psychiatrists) is in defiance of established WHO taxonomic principles, particularly as research from Spain presented at the Ft Lauderdale International Conference emphasised that ME/CFS and fibromyalgia are two genetically distinguishable illnesses

- **The Guideline Development Group should include individuals from all the relevant professional groups:** the Draft Guideline fails this criterion: whilst mental health professionals are well represented on the Guideline Development Group, and whilst there is a neurologist and an immunologist listed, their experience of patients with ME/CFS is not known. Conspicuous by their absence are a virologist, a clinical allergist, a microbiologist, an endocrinologist, a pharmacologist, a rheumatologist, a molecular biologist, a biochemist, a biostatistician, and experts in vascular medicine, nuclear medicine and genomics, all of whose input is essential to understanding the nature of ME/CFS

- **The patients' views and preference should be sought and the patient /carer members must have equal status on the GDG**: the Draft Guideline pays lip-service to the need to listen to patients' and carers' views but then entirely ignores them when they have been submitted

- **The health benefits, side effects and risks should be considered when formulating the recommendations:** the Draft Guideline fails in this respect. All relevant patient surveys consistently report that a high percentage of patients are made worse by exercise therapy. Failure to report such adverse events may constitute research misconduct

- **The potential cost implications of applying the recommendations should be considered:** the Draft Guideline fails this criterion. Assessment of cost-effectiveness must be carried out in respect of maximising health gain so that resources are not employed in interventions that are not cost-effective, but it is already known that the only recommendations in the Draft Guideline – CBT/GET – have very limited (and certainly not lasting) benefit and are not in any way curative, as recognised by even its keenest advocates. Moreover, there is substantial evidence that patients with ME/CFS are actually made worse by these recommended interventions. Further, the cost implications of recruiting, training and supervising an army of behavioural therapists needed to deliver NICE's recommendations will be considerable. Given that its recommended intervention is already known to have no lasting benefit, how can NICE's recommendations be considered cost-effective?

- **There should be an explicit link between the recommendations and the supporting evidence:** the Draft Guideline fails this criterion: the alleged "evidence-base" is exceptionally weak yet NICE gives it more weighting than the patients' evidence, when there should be equal weighting

- **The Guideline should be editorially independent from the funding body:** the funding body for NICE is the Department of Health; does NICE pay its editorial and other advisers with funding received from the Department of Health? If so, funding is not independent. If not, from where does it get any additional funding?

5. Second term of reference: Whether public confidence in NICE is waning, and if so why

5.1 Public confidence in NICE is indeed waning: Given the extent and high calibre of the biomedical evidence known to have been submitted to – but ignored by – NICE, it is obvious that NICE's remit is to produce policy-based evidence instead of evidence-based policy. Its cavalier disregard of so much credible biomedical evidence justifies the public lack of confidence in NICE.

6. Third term of reference: NICE's evaluation process and whether any particular groups are disadvantaged by the process

6.1 Patients with ME/CFS are at risk of being actively damaged by NICE's biased evaluation process: for NICE's evaluation process to exclude the evidence that its recommended regime is potentially harmful puts those with ME/CFS at immediate and unacceptable risk.

6.2 Patients with ME/CFS are disadvantaged by NICE's consultation process: for its own convenience, NICE insists that all comments on its Draft Guideline be submitted online, but many patients with ME/CFS do not have a computer or may be too sick to

use one. This means that a significant proportion of the patients' voice is excluded, which is in breach of the AGREE Instrument to which NICE is party.

7. Fourth term of reference: the speed of publishing guidance:

7.1 The time taken by NICE to produce any of its Guidelines is unacceptably slow: in the case of ME/CFS, it is now over five years since the publication of the Chief Medical Officer's Report of January 2002 and still no Guideline has been produced.

8. Remaining Health Select Committee Terms of Reference

8.1 We have no comment to make concerning the Health Select Committee's remaining terms of reference.