

Paradoxical Proliferation of Professorial Psychiatry?

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The Editorial “[What Causes chronic fatigue syndrome?](#)” by psychiatrist Peter White in the current issue of the BMJ (2004: October 23:329:928-929) makes interesting reading, but is it “evidence-based” medicine? People need to judge for themselves and they could start by looking at the 92 page list of published references on ME / ICD-CFS that question the stance taken by White.

The reference list can be viewed at

http://www.meactionuk.org.uk/SUBJECT_INDEX.htm.

Those references cover many aspects of ME / ICD-CFS including historical papers; “general” papers that include demonstrated muscle abnormalities; laboratory findings; neurological factors; evidence of demyelination and cerebral oedema; neuroendocrine factors; quality of life; respiratory problems; severity and chronicity; virological aspects; acute stress as a precipitating factor; liver involvement; bladder and gut problems; immunological abnormalities; allergies and hypersensitivities; hair loss; mouth ulcers; cardiac problems; vascular problems, ocular problems; problems with anaesthesia, and nuclear medicine findings of abnormalities in brain perfusion. They also contain psychological papers that do not agree with the “Wessely School” beliefs, including papers that show cognitive dysfunction to be seven-fold worse than either the control or the depressed group and to be more severe than assumed by the CDC (1994) criteria, showing a pattern of brain behaviour supporting neurological compromise in ME / ICD-CFS. The references also contain a section that documents previous psychiatric misdiagnosis of what were then “medically unexplained” disorders such as multiple sclerosis, Parkinson’s disease, diabetes, epilepsy, asthma and thyroid disorders, to name but a few.

White’s assertion that “Research about its cause has been hampered by the absence of a biological marker” causes a sharp intake of breath, as the medical, scientific and lay communities all know that whilst several biomarkers already exist, in the UK, the continued absence of a definitive biomarker is due to the absolute refusal of Government and government-funded bodies such as the MRC (who have been overly-influenced by psychiatrists of the “Wessely School”) to fund any research that would reveal such biomarkers, yet sums of £11.1m are made available to these same psychiatrists who have vested interests in claiming “CFS/ME” as a psychosocial disorder.

It is noted that having had his vested interests publicly exposed (see “Notes on the involvement of Wessely et al with the Insurance Industry and how they deal with ME/CFS claims”, particularly Appendix I that addresses the role of Peter Denton White as Chief Medical Officer for Swiss Re, which can be found at http://www.meactionuk.org.uk/Notes_on_the_Insurance_issue_in_ME.htm), White does now declare his own competing interests as being “consultancy work with the Department for Work and Pensions -- formerly the Department of Social Security --

and with the re-insurance company Swiss Re". People may draw their own conclusions about such competing interests.

In his BMJ Editorial White states "Women get chronic fatigue syndrome more commonly than men for unknown reasons": is it not curious that he entirely fails to mention the evidence that ME / ICD-CFS is an autoimmune disorder (presented some years ago at an AACFS international conference and subsequently in the literature) and the well-documented increased incidence of **all** autoimmune disorders in women? Why would White ignore this evidence?

White also states "Premorbid mood disorders are replicated risk markers for chronic fatigue syndrome": this may be so for "Wessely School" medically unexplained chronic fatigue, but it not so for ME / ICD-CFS patients who fulfil the Ramsay description of ME, nor does White cite any supportive research on those with ME as distinct from those with heterogeneous CFS.

White states "Patients with chronic fatigue syndrome underestimate their cognitive and physical abilities, while being more aware of their internal physiological state, a phenomenon called interoception". This term appears to arise from a 2001 Oxford publication on "visceral sensory neuroscience" (White's reference 10) but according to the Oxford Concise Medical Dictionary, the word "interoceptor" means "any receptor organ composed of sensory nerve cells that respond to and monitor changes within the body, such as the acidity of the blood". The word "interoception" is not listed, nor is it listed in the Unwin Hyman Medical Dictionary, but seemingly White has latched onto this word and perceives it to be a useful descriptor in support of his own beliefs.

White's statement in his Editorial that patients are "more aware of their internal physiological state" than he appears to think is reasonable, together with his statement that "this enhanced body awareness or interoception may itself cause sedentary behaviour" need to be robustly challenged.

Can White really be looking at patients with ME / ICD-CFS or is he looking at those with a primary complaint of the "Wessely School" construct, namely, one end of a continuum of "medically unexplained fatigue"?

Patients with ME / ICD-CFS whose lives are wrecked by balance problems (including frank vertigo), recurrent pancreatitis, myocarditis, recurrent episodes of intense, crushing chest pain that are clinically indistinguishable from cardiac infarction, neuromuscular incoordination (including difficulties with swallowing and fine finger coordination, for example, doing up buttons or turning pages of a book), difficulty getting enough air into the lungs, incapacitating post-exertional exhaustion (which is nothing like being "tired all the time"), intractable muscle pain and frequency of micturition (at the 7th AACFS International Conference held in Madison, Wisconsin from 8 -10th October 2004, Dr Ritchie Shoemaker said that people with ME / ICD-CFS "are very dehydrated because they urinate water out so rapidly" --- see Jan van Roijen's Help ME Circle post of 15th October 2004 from richvank@aol.com) would indeed be psychologically disturbed if they were **not** appropriately and legitimately concerned about such distressing symptoms.

It is unacceptable for such symptoms to be either dismissed or ignored by those who prefer not to accord them even minimal consideration, but regardless of the evidence of significant organic pathology, White inevitably concludes his Editorial in his customary way: “Treatments (*sic*) that ‘reprogramme’ interoception such as graded exercise therapy and cognitive behaviour therapy, seem to help most patients”.

One must again ask why White ignores the substantial evidence held by various ME charities that such regimes are actively harmful for those with ME / ICD-CFS.

What will it take for psychiatrists of the “Wessely School” to engage with reality concerning ME / ICD-CFS? It is of the utmost concern that they appear ever more influential and inviolable: indeed, a count of “Professors” who are associated with the “Wessely School” reveals a now mesmeric figure, and the funders of such Chairs are not difficult to identify.

It seems that for members of the “Wessely School” of “CFS/ME”, Chairs in various aspects of Psychiatry, Psychology and now the new discipline of Psychosocial Disability are proliferating in inverse proportion to the emerging data that shows the holders of these academic posts to be wrong about ME / ICD-CFS. Moreover, the continued failure by the holders of these posts to address the issues is likely to have untold consequences for countless numbers of suffering humanity.

Have all these Professors so little regard for such suffering that they are content to continue to dismiss and ignore it?

Is this because in modern medicine, newly qualifying doctors no longer swear the Hippocratic Oath (First do no harm) but merely promise primary allegiance to their medical colleagues over and above their patients?