www.margaretwilliams.me

Key issues for Judicial Review of the NICE Guideline on "CFS/ME"

Margaret Williams

25th October 2007

Introduction

Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS) is a serious problem in the UK and worldwide. In the UK, it is five times more prevalent than HIV/AIDS. An ME/CFS patient "*feels effectively the same every day as an AIDS patient feels two weeks before death*" (Dr Mark Loveless, Head of AIDS and ME/CFS Clinic).

According to Professor Nancy Klimas, internationally acknowledged expert on the disorder: "*Our patients are terribly ill, misunderstood, and suffer at the hands of a poorly-informed medical establishment and society. There is evidence that the patients with this illness experience a level of disability that is equal to that of patients with late-stage AIDS, patients undergoing chemotherapy (and) patients with multiple sclerosis".*

The cardiac index of ME/CFS patients is so severe that it falls between the value of patients with myocardial infarction (heart attack) and those in shock (Professor Paul Cheney, expert on the cardiac dysfunction in ME/CFS).

Since 1969, the World Health Organisation has classified ME/CFS as a neurological disorder (i.e. as an organic, not psychiatric disorder). The UK Department of Health was compelled to accept this classification as fact but does not accept that the classification is correct; instead, UK Departments of State and their agencies (such as the Medical Research Council) classify ME/CFS as a mental (behavioural) disorder based on nothing but the personal (and demonstrably flawed) beliefs of a small group of psychiatrists who are Government advisers (the Wessely School).

NICE has "taken into account matters which it ought not to take into account and has refused to take into account or neglected to take into account matters which it ought to take into account" (the Wednesbury unreasonable principle).

NICE has disregarded significant research that has revealed multi-system biomedical abnormalities as demonstrated by laboratory, nuclear medical and clinical investigations.

Despite having been brought to its specific attention, NICE has systematically and deliberately ignored the evidence of over 4,000 published peer-reviewed papers in the international literature and has relied upon the biased beliefs of the UK psychiatric lobby. Not only does the NICE Guideline stipulate that non-psychiatric therapies that have been found to be helpful (such as thyroxine and nutritional supplements) must not be used, it stipulates that the first line management regime must be psychiatric, with mind-altering therapies (cognitive behavioural therapy, or CBT) aimed at changing a patient's beliefs that the disorder is organic, together with exercise (graded exercise therapy, or GET, also known as "rehabilitation") that have already been shown (a) not to be effective and (b) to be dangerous for those with ME/CFS as opposed to people with other (psychiatric) fatigue syndromes.

For example, in the Guideline, reference is still made to *"unhelpful beliefs",* to "*the relationship between thoughts, feelings, behaviours and symptoms and the distinction between causal and perpetuating factors"* and to the fact that the CBT plan will include "*identifying perpetuating factors that may maintain CFS/ME symptoms"* and will address "*any over-vigilance to symptoms"*.

This is wholly unacceptable: it demeans people with ME/CFS and it ignores the substantial evidence that ME/CFS is not a psychosocial disorder.

It is insufficient for the NICE Guideline Development Group (GDG) to claim that consideration of the biomedical evidence did not come within its remit – it was charged with providing guidance on the diagnosis of "CFS/ME", so the literature which demonstrates the clear biomedical aetiology should have formed part of the literature review.

At least two-thirds of the GDG members had previously exhibited published psychiatric bias and support of the psychiatric paradigm.

Despite being drawn to the attention of the GDG, research that indicates potential dangers of the recommended management regime was ignored.

Gene expression research has revealed that there are seven types of "CFS", with evidence of different clinical symptoms and severity for each sub-type. NICE has ignored this evidence and has accepted the psychiatric paradigm that "CFS/ME" is a behavioural disorder.

Specific problems with NICE in relation to its Guideline on "CFS/ME"

For an in-depth analysis, see
http://www.meactionuk.org.uk/Concerns_re_NICE_Draft.pdf

The NICE Guideline was condemned by UK charities as unfit for purpose.

Brief summary of concerns

Following the consultation process on the Draft Guideline on “CFS/ME” issued on 29th September 2006, NICE was compelled to delay publication of the final Guideline due to the unprecedented volume of responses, so it was not published until 22nd August 2007 (four months late).

The AGREE Instrument

In the production of its Guideline on “CFS/ME”, NICE was in clear breach of the AGREE Instrument.

NICE is a party to the Appraisal of Guidelines Research and Evaluation Instrument (known as the AGREE Instrument). This originates from an international collaboration of researchers and policy makers working together to improve the quality and effectiveness of clinical practice Guidelines. The AGREE Collaboration started in 1998 as a project funded by the European Union, the main objectives being to develop an appraisal instrument to assess clinical Guidelines themselves and to harmonise Guideline development across Europe in order to ensure the dissemination of high-quality Guidelines.

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.

In its Guideline on “CFS/ME”, NICE disregarded the following:

- **There should be an explicit statement that all group members have declared whether they have any conflicts of interest** (no such conflicts of interest were initially declared: indeed, such competing interests were denied. It was not until such competing interests were exposed by the ME community that NICE issued a correction in October 2007 in which the competing interests of the GDG were listed)

- **The patients to whom the Guideline is meant to apply should be specifically described** (the Guideline completely failed 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 different disorders together as one single disorder is in defiance of established taxonomic principles)

- **The Guideline Development Group should include individuals from all the relevant professional groups** (the Guideline failed this criterion in relation to ME/CFS: whilst physiotherapists, occupational therapists, clinical psychologists, occupational health physicians, nurses, dieticians, general practitioners, and liaison psychiatrists were represented on the Guideline Development Group, and whilst there was a neurologist and an immunologist listed, their experience of patients with ME/CFS is not known. Conspicuous by their absence, however, were a virologist, a clinical allergist, a microbiologist, an endocrinologist, a pharmacologist, a rheumatologist, a molecular biologist, a biochemist, 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 preferences should be sought and the patient/carer members must have equal status on the GDG** (the Guideline paid lip-service to the need to listen to patients' views but the recommendations then largely ignored them)

- **The health benefits, side effects and risks should be considered when formulating the recommendations** (the Guideline failed in this respect: all relevant patient surveys have consistently reported that a high percentage are made worse by GET. Failure to mention such adverse events is a research crime)

- **The potential cost implications of applying the recommendations should be considered** (the Guideline failed 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 the only recommendations in the Guideline – CBT and 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 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 would be considerable. How therefore can the recommendations be considered cost-effective?)

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

- **The Guideline should be editorially independent from the funding body** (NICE is funded by the Department of Health)

- **Systematic methods should be used to search for evidence** (this is a serious issue: for example, the integrity of the York Systematic Review that purports to support the recommendations has been extensively exposed as biased, since

> evidence that militates against the NICE recommendations has been omitted, with the result that the favoured recommendations appear in a better light than is justified by the totality of the evidence. Anne-Marie Bagnall, for example, published different conclusions from the same material: ie. JAMA 2001 and the update in JRSM 2006 that underpins the Guideline, but she does not explain how she now reaches different conclusions using the same evidence-base).

When Guidelines are based on such highly inconsistent literature, the recommendations that are based on that literature become invalid, not least because the severity of ME/CFS is deliberately obscured and patients' rights to appropriate care are obliterated (which contravenes the AGREE Instrument).

NICE was entrusted to produce a Guideline that is accurate but has failed to do so, partially because the York Review team has misled NICE in that the shortcoming of CBT/GET (that they themselves highlighted in JAMA in 2001) have now been diluted and deleted from the current update that purports to be a comprehensive and balanced scrutiny of the relevant literature.

The assertion of Wessely School psychiatrists that mixing 'fatiguing illnesses' will clarify the pathophysiology of 'fatigue' has not held up: on the contrary, it has failed to yield any meaningful diagnostic or therapeutic protocols (Co-Cure ACT: 12th October 2004).

The Wessely School's vociferous claim that they will accept only "evidence-based medicine" in relation to "CFS/ME" has been exposed as duplicitous, since their own so-called "evidence" and their own studies that claim to provide this "evidence" have, for over a decade, been exposed in the literature as methodologically flawed, for example, unrepresentative selectivity of cohorts; outright bias; manipulation of cited references, for example, leaving out findings from cited studies that were inconsistent with their own conclusions; excessive self-references; distorted interpretation of results, such as presenting assumptions and taking for granted what still needs to be explained; generating conclusions before generating the data to support such conclusions; using mixed populations but failing to disaggregate the findings; mischaracterisation of the facts; using different timing measures, for example, drawing conclusions across different studies, eg. equating simple fatigue of 30 days with chronic severe fatigue lasting decades; use of different diagnostic instruments; use of different definitions of improvement; failure to assess the adequacy of the analyses performed; failure to address the very high drop-out rates; misrepresentation of study results, for example, in one cited study, an overwhelming majority of participants who had been categorised by the authors as 'recovered' rated themselves as only slightly improved and less than halfway back to pre-morbid health levels; studying 'fatigue' but then claiming their results relate to "CFS/ME" – when the literature plainly states that such results cannot be so interpreted (see Arch Intern Med 1995:155:2105-2110; see also QJMed 1997:90:723-727).

For the York Systematic Review team to have used such flawed studies as the basis of the recommendations to NICE may well amount to research misconduct. (For a more detailed discussion of the flawed methodology of the Wessely School, see www.meactionuk.org.uk/consideration.htm).

These notes should be read in conjunction with "NICE: GIGO (GARBAGE IN, GARBAGE OUT)?" available at http://www.meactionuk.org.uk/NICE_-_GIGA.htm

Quotations about NICE from Professor Bruce Charlton of St Bartholomew's Hospital, London, set out in the above document, include the following:

"NICE is not about science, it is about government and managers attaining the statutory power to control doctors".

"Data input is selective, analysis is selective, and the results are selective. The watchword is GIGO – 'garbage-in, garbage-out'. Conclusions cannot be stronger than the validity of the database from which they were generated".

"NICE redefines 'science' as being whatever is the outcome of its deliberations".

For these and other credible reasons, it is imperative to bring an action for Judicial Review to prevent more unnecessary suffering and deaths.