

18th August 2003 - 8th September 2003

An exchange of letters between the Countess of Mar and the Dean of the Institute of Psychiatry Dr George Szmukler relating to the wrongful classification of ME/CFS.

To: Dr George Szmukler, Dean of Psychiatry, Institute of Psychiatry, Kings College London,
De Crespigny Park, Denmark Hill, LONDON. SE5 8AF

18th August 2003

Dear Dr Szmukler

As Patron of a myalgic encephalomyelitis (ME) research charity, I have seen the letter of 11th August 2003 written on your behalf by your Executive Assistant Matt Smart to Diana Organ MP and I must express immediate concern about the misinformation it conveys to a Member of Parliament and hence to the wider community. Whilst skilfully worded, the letter does not adequately address the facts: it is misleading to state that the International Classification of Diseases 10th Revision “classifies the symptoms included in the research definition of CFS as ‘neurasthenia’ in the mental health chapter (code F48.0)”. Further, it is disingenuous to state that “although ME is not classed as a mental disorder within ICD-10, in adaptation for the UK the guide acknowledged that CFS is often referred to as ME” without then explaining that “CFS” is a heterogeneous label and as such means entirely different things to different people.

ME has been listed as a disorder of the brain in the International Classification of Diseases (ICD) since 1969 and in ICD10, published in 1992, the term Chronic Fatigue Syndrome is listed as one by which the disorder ME may also be known. In the ICD10, both ME and CFS are coded at G93.3 under Disorders of the Brain, whilst other chronic fatigue states (including neurasthenia) are coded at Section F48.0 under Mental and Behavioural Disorders, a category from which ME / Chronic Fatigue Syndrome is expressly excluded by the World Health Organisation and the World Health Assembly.

The issue at stake here is that in the Guide to Mental Health in Primary Care, Professor Simon Wessely includes ME as a mental disorder, categorically stating that CFS “may be known as ME”, whilst on the King’s College (recently re-vamped) website, it asserts that “CFS has officially replaced the term M.E”, when such is not the case under the auspices of the WHO. Senior staff at WHO Headquarters in Geneva have expressed dismay that the same condition (“CFS”) should be differently categorised under the one WHO banner and have stated that this is “unacceptable”. Indeed, Dr B Saraceno, Director of the Department of Mental Health at the WHO, has confirmed in writing the classifications of neurasthenia, fatigue syndrome, postviral fatigue syndrome and myalgic encephalomyelitis in the following terms: “Let me state clearly that the World Health Organisation has not changed its position on these disorders since the publication of the International Classification of Diseases, 10th edition, in 1992 and versions of it during later years. Postviral fatigue syndrome remains under diseases of the nervous system as G93.3 (and) ME is included within this category. It is

possible that one of the several WHO Collaborating Centres in the United Kingdom presented a view that is at variance with WHO's position".

You will doubtless be aware that as a result of legitimate complaints, Professor Rachel Jenkins, Director of the WHO Collaborating Centre for Mental Health Research and Training at the Institute of Psychiatry, is currently preparing an erratum slip to correct the misinformation about ME contained in the WHO Guide to Mental Health in Primary Care issued in the UK (where ME is erroneously re-classified by Simon Wessely as a "mental" disorder in direct contravention of the WHO's own classification, since Collaborating Centres are not permitted to change classifications without the approval of the World Health Assembly).

If the briefing provided for Mr Smart by the WHO Collaborating Centre for Mental Health is accurately reflected in that letter, then it is apparent that the WHO Collaborating Centre for Mental Health under the directorship of Professor Jenkins continues to labour under the well-published misconceptions of Professor Simon Wessely about the cardinal differences between the internationally-used term "CFS" (which largely equates with ME) and his personal interpretation and use of the identical term.

Concern has repeatedly been expressed by the international research community over Professor Wessely's hijacking of the term "CFS" to mean somatoform disorder, as exemplified by Fred Friedberg, Clinical Professor in the Department of Psychiatry at the State University of New York, who in a paper in the Journal of Chronic Fatigue Syndrome (JCFS:1999:5:3-4:149-159) states: "descriptive studies of CFS patients in England, the US and Australia suggest that the CFS population studied in England shows substantial similarities to depression, somatization or phobia patients, while the US and Australian research samples more closely resemble fatiguing neurological illnesses".

I myself have raised the issue of Professor Wessely's continued denial of important biomarkers of the organic pathoaetiology of ME/ICD-CFS on numerous occasions in the House of Lords (all recorded in Hansard); I have personally met the previous Chief Medical Officer and have provided Ministers with abundant documented concerns about Professor Wessely, who consistently dismisses, trivialises or ignores the published scientific evidence about the nature of ME/ICD-CFS, which is now considerable. I have also obtained an opinion from a leading Queen's Counsel and I quote briefly from that Advice:

"On the document you have sent me there is an overwhelming case for the setting up of an immediate independent investigation as to whether the nature, cause and treatment of ME as considered by the Wessely School is acceptable or consistent with good and safe medical practice. There is substantial doubt as to whether such could be the case. It is, of course, open to patients (and) their parents to seek Judicial Review".

You will doubtless be aware of the major legal action currently before the High Court (claim number HQ02X02679) in which Professor Wessely, Kings College Hospital NHS Trust Corporate Legal Services and the South London and Maudsley NHS Trust are Defendants and of the fact that Legal Aid has been granted to pursue the action. You will know that it is an action for damages arising from the Defendants' alleged clinical negligence and from their alleged breach of duty in connection with the non- investigation of disease, the non-provision of medical facilities for diagnosis and/or sufficient testing necessary to provide adequate pathophysiological information on which to base a rational treatment programme. You may

also be aware that the High Court Master assigned to the case (Master Yoxall) has made it clear that he will not permit the action to be struck out. Whether Professor Wessely's beliefs are personal or political will doubtless be clarified in the High Court.

For the avoidance of doubt, may I set out a few salient facts, all of which are readily verifiable.

ME has been recognised and described in the medical literature since 1938, with the seminal paper being that by Wallis in 1957; Sir Donald Acheson's (a former Chief Medical Officer) major review of ME was published in 1959; in 1962 the distinguished neurologist Lord Brain included ME in the standard textbook of neurology and in 1978 the Royal Society of Medicine accepted ME as a distinct clinical entity. In 1988 both the UK Department of Health and Social Services and the British Medical Association officially recognised it as a legitimate and distressing condition and this is a matter of record.

Following an immense increase in the incidence of ME in the USA, the term "Chronic Fatigue Syndrome" (shortened to "CFS") was coined in 1988 in a Working Case Definition formulated by Gary Holmes and Anthony Komaroff et al (Annals of Internal Medicine 1988;108:387-389). Whilst that paper focused on one primary symptom (fatigue) and bore little relationship to the symptoms being complained of, most notably post-exertional exhaustion and myalgia (not "fatigue") and profound malaise accompanied by a variety of neurological sequelae, together with gastro-intestinal, cardiovascular and reticulo-endothelial involvement, it did not include in its definition patients suffering from somatoform disorder, and the term "neurasthenia" is not mentioned. Instead the definition identifies a "possibly unique clinical entity" which was previously known as ME. Importantly, the authors state that clinical conditions which must be excluded from the case definition include chronic psychiatric disease and the definition specifies that physical symptoms must be documented by a physician.

In March 1990 a meeting took place at Green College, Oxford: it was convened by three psychiatrists and chaired by a fourth (Professor Anthony Clare) who, with some exasperation, informed those present that there was only one reason for calling the meeting and that was "a group of patients with a cluster of symptoms who get a lot of publicity". This meeting resulted in the 1991 CFS criteria (known as the Oxford criteria), from which the cardinal symptoms of ME/ICD-CFS and all physical signs long documented in the international ME literature were specifically excluded and the ME case definition was diluted to include all forms of medically unexplained "fatigue" present for at least six months. Further, the 1991 criteria expressly state that psychiatric disorders (particularly depressive illness, anxiety disorders and hyperventilation syndrome) are not reasons for exclusion from a diagnosis of "CFS".

This was the real start of the drive by Professor Wessely and his colleagues to "eradicate" ME and to classify "CFS" as psychiatric, although he had been on such a course since about 1988 when he gained notoriety through his involvement in the Ean Proctor case, where he was personally instrumental in getting a child with severe ME forcibly removed from his parents and taken under police presence into "care".

Whilst confusion reigned in the UK over the two different meanings of the same term "CFS", in 1990 the American Medical Association was forced to issue a correction and apology for confusing syndromes of "chronic fatigue" with the "chronic fatigue syndrome" and stated

categorically that the two are not the same, a distinction which Professor Wessely is apparently determined to ignore.

In 1994, the US Centres for Disease Control (CDC) produced “revised” criteria for defining cases of “CFS”, in the formulation of which both Simon Wessely and psychiatrist Michael Sharpe were instrumental. This research tool unequivocally states that the authors dropped all physical signs from the inclusion criteria and, crucially, that anxiety disorders, somatoform disorders and neurasthenia “should no longer exclude a patient from the diagnosis of unexplained chronic fatigue”. This once again ensured the inclusion of virtually all cases of medically unexplained chronic “fatigue” (and “fatigue” is prevalent in almost all psychiatric disorders) as distinct from those suffering from the more strictly-defined Chronic Fatigue Syndrome / ME as classified in ICD10 at G93.3. Indeed, the authors emphasise that “whether to retain any symptom other than chronic fatigue generated the most disagreement among the authors”, a fact which underlines the intended direction of the dominant psychiatric lobby.

Thus the term “CFS” has come to mean different things to different people: to some of the international biomedical research community, it equates with ICD-classified ME (where in nearly all cases there are signs and symptoms of disease of the central nervous system), but to a small group of UK psychiatrists led by Professor Wessely, it equates with a functional somatic syndrome or somatoform disorder, for which they believe that cognitive behavioural therapy including graded exercise should be the treatment of choice.

Neither the 1991 Oxford criteria nor the 1994 CDC criteria with their heavy emphasis on a psychiatric cause accurately reflects the clinical situation experienced by patients and there have been mounting calls for a further revision of the ME/ICD-CFS case definition, which is why the Canadian case definition was produced and why it is deemed to be so important by those medical researchers and clinicians who are aware that it is well recognised that the undifferentiated term “CFS” is now much too broad to be useful (JCFS 2003;11(1):7-115).

The truth about ME/ICD-CFS is still being suppressed and denied by Professor Wessely and his supporters and by those whom they control and influence: their dogma is that “CFS” is an “abnormal illness belief” resulting in deconditioning which must not be comprehensively investigated, treated or validated; those claiming to suffer from it must not be “pandered” to by “naïve” physicians and must not be given social services support, state benefits or insurance payments. In contrast, in the US Professor Anthony Komaroff states: “There is now considerable evidence of an underlying biological process (which) is inconsistent with the hypothesis that (ME/ICD-CFS) involves symptoms that are only imagined or amplified because of underlying psychiatric distress. It is time to put that hypothesis to rest” (Am J Med 2000;108:99-105).

It is my opinion that this is not ignorance but deliberate misrepresentation and determined suppression by Professor Wessely of the available international medical and scientific evidence for over 16 years. For psychiatrists of the “Wessely School” to continue to insist that they are relying on “evidence-based medicine” and repeatedly to recommend psychotherapy as the best management strategy is a wholly deplorable situation which I intend to raise once again in the House after the recess, where I shall use Mr Smart’s letter in evidence.

Without doubt, patients have been harmed by Professor Wessely’s endless assertions that ME does not exist and by his unsubstantiated claim that previous studies of ME “reflect those

who seek treatment rather than those who suffer the symptoms” and that “there lies at the heart of CFS not a virus (or) immune disorder, but a distortion of the doctor-patient relationship” and his contention that “the description given by a leading (doctor) at The Mayo Clinic remains accurate: ‘the doctor will see that they are neurotic and he will be disgusted with them’ ”.

One immediate practical example is that the NHS Information Authority has confirmed in writing that “the source of the coding for Chronic Fatigue Syndrome in the Mental Health Minimum Data Set (MHMDS) Data Manual is the WHO guidance on Mental Health for Primary Care” (sic). As this “information” has been distributed throughout the NHS, the harm flowing from it is unquantifiable but entirely preventable and consequently it is expected that further legal actions will follow.

Finally, I enclose an article called “Tired and emotional” by Helen Sewell published in the Observer on Sunday 17th August 2003 which graphically illustrates how dire the ME situation remains.

I look forward to receiving your assurance that you will address the issues I have brought to your attention.

Yours sincerely

The Countess of Mar

cc Diana Organ MP

The Chief Medical Officer for England and Wales

Professor Simon Wessely

To: The Rt. Hon. the Countess of Mar, House of Lords, London. SW1A 0PW

27th August 2003

Dear Lady Mar,

Thank you for your letter of 18th August 2003 in which you ask me to address issues relating to the classification of ME and CFS, and the work of Professor Simon Wessely.

I do not think it is appropriate for me to enter into a debate about nomenclature and classification. The area remains somewhat controversial, although I understand that among the scientific community there is less disagreement than your letter suggests. The Report of the Working Party on CFS/ME to the Chief Medical Officer for England and Wales makes this clear. It is fully accepted that CFS/ME is a real and serious illness, and Professor Wessely's views are entirely consistent with this. A recent editorial in the Lancet (Jan 12th. 2002) co-authored, amongst others, by Professor Wessely and Christopher Clark, Chief Executive of Action for ME, further supports an emerging consensus.

I would like to say a few things about Professor Wessely. Questions about CFS/ME should be resolved through research, with rigorous scrutiny of the methods, findings and conclusions by the community of scientists devoted to the field. By these standards, Professor Wessely must be judged one of the outstanding medical researchers in the UK, and indeed internationally. His research has been regularly and continuously funded by bodies such as the Medical Research Council and the Wellcome Trust which exercise the most demanding levels of peer review. Similarly, the publication of Professor Wessely's research findings has consistently and predominantly been in journals in which submissions are again subject to the most exacting scrutiny by his scientific peers. Professor Wessely has been awarded a Research Medal by the Royal College of Physicians (specifically for work on CFS) and he has served on many prestigious scientific committees further attesting to the high regard in which he is held by the scientific community. I note also that some of his research projects have involved collaboration with patient groups themselves.

The Institute of Psychiatry thus has every reason to have confidence in the quality and integrity of Professor Wessely's research.

Yours faithfully

[Signed]

Dr George Szukler

Dean

Cc Diana Organ MP

Chief Medical Officer for England and Wales

To: Dr George Szukler, Dean of Psychiatry, Box 001, De Crespigny Park, Denmark Hill, London. SE5 8AT

2nd September 2003

Dear Dr Szukler

Your response of 27th August 2003 exactly typifies the problem that ME/ICD-CFS patients have to contend with: plainly, you chose to see only what you wanted to see instead of the reality of the situation.

Apart from the anticipated eulogy of Professor Wessely, you have not addressed the central issues which I specifically asked you to deal with, namely the incorrect inclusion of ME/ICD-CFS in the UK Guide to Mental Health in Primary Care, and the need to distinguish between ME/ICD-CFS and the chronic fatigue found in somatoform disorder, when those are the very issues which fuel this furor.

You state that "*the area remains somewhat controversial*" but there can be no controversy about the fact that ME/ICD-CFS is classified by the WHO under "Diseases of the Nervous

System". The controversy to which you refer is between the minority view of some psychiatrists and the majority view of the international research community: the latter accepts the biomedical science and the clinical signs exhibited in ME/ICD-CFS as being consistent with organic disturbance of the neuro-endocrine, immunological and cardiovascular systems, not somatisation disorder, whilst the former does not. It is Professor Wessely who has sought deliberately to usurp the authority of the WHO by departing from its clearly written classification as set out in the ICD, despite the fact that the WHO has confirmed that the present classification will not be subject to any revision in the foreseeable future and, specifically, that there is no intention to move ME from a neurological to a psychiatric classification.

You claim that "*amongst the scientific community there is less disagreement than your letter suggests*": whilst I am aware that this may be so amongst certain self-proclaimed and vociferous "experts" in the UK psychiatric community, it is certainly not the case amongst the biomedical community and I drew the international concern about this to your attention in my letter of 18 August 2003.

In your reply you rely on the CMO's report on "CFS/ME", but may I remind you that the CMO's report was stringently criticised for unscrupulously but purposely stating "*Currently, CFS and ME are classified as distinct illnesses in the WHO's International Classification of Diseases*" (page 5, section 1.4.1) without clarifying that ME (and including CFS as one of the terms by which ME is known) is unequivocally classified under Diseases of the Nervous System as one and the same disorder, thus the CMO's report is gravely misleading about this pivotal matter. It is known that this was because the outcome of the CMO's report was governed by the same group of psychiatrists who are on record as asserting that ME does not exist and that CFS is a somatisation disorder. Had the report been transparent about the WHO classification of ME, then the fallacy of the preferred psychiatric management strategy which the report recommends would have been exposed. Since the CMO's report also states "*a resolution (of definitions and terminology) is beyond the scope of this report*", clearly this key issue is far from being resolved as you imply.

You refer to an "*emerging consensus*" about "CFS/ME" which is acceptable not only to Professor Wessely but also to Chris Clark, Chief Executive of Action for ME: it is true that, to the dismay of many long-term sufferers of ME, under Chris Clark's direction AfME has chosen to support the currently fashionable psychiatric management of ME/ICD-CFS as set out in the CMO's report and also in the MRC's report on the direction of future research into the condition, as a result of which AfME has been awarded substantial funding by Government. It is a matter of record that AfME even changed its logo to read "Action for ME and chronic fatigue" but was compelled to remove the words "and chronic fatigue" by the Charity Commission because that is not the purpose for which the charity is registered.

As I'm sure you will accept, on-going or chronic fatigue is an acknowledged feature not only of most psychiatric disorders but also of many organic disorders, including many neurological conditions, cancer, chronic infectious diseases, blood and respiratory disorders, but no-one suggests that such disparate disorders should all have identical medical management in the form of cognitive behavioural therapy and forced graded exercise. In the same way, the management of chronic fatigue is different from the management of ME/ICD-CFS because the two are not the same: 13 years after this was publicly acknowledged by the American Medical Association, it is finally recognised in the UK also, at least by Dr Leonie Ridsdale, who might be said to be a supporter of Professor Wessely ([Distinguishing patients](#)

with chronic fatigue from those with chronic fatigue syndrome: a diagnostic study in UK primary care. Darbishire L, Ridsdale L, Seed PT. *British Journal of General Practice* 2003 June;53(491):441-445).

The reason I wrote to you was because ME/ICD-CFS is not classified by the WHO as a mental disorder yet it is included in the UK Guide to Mental Health in Primary Care. Significantly, the Guide clearly states in its Introduction that it contains a list of categories of **mental disorders from the ICD-10 classification consistent with the main ICD-10 classification (ie. each diagnosis and diagnostic category is claimed to correspond to those in ICD-10)**. This being so, on what credible grounds was ME/ICD-CFS included in the Guide? Its inclusion is seen as outright deception which provides false guidance for GPs, many of whom express concern about this situation far in excess of that shown in your letter.

It is notable that, notwithstanding his assertion about the classification of ME in the Guide to Mental Health, Professor Wessely has acknowledged in writing that ME/ICD-CFS is not classified by the WHO at section F48 a mental disorder. What is the explanation for this discrepancy? Clearly the issue with which I asked you to engage remains to be addressed: ME/ICD-CFS is wrongly included in the Guide to Mental Health compiled by the Institute of Psychiatry of which you are Dean. Is it the case that you see expediency and the funding it can bring as being more important than clinical accuracy?

This matter of correct classification is of supreme importance to patients, not only because of the resultant financial consequences (because those with a psychiatric label are denied certain state benefits as well as medical insurance payment) but also because if their disorder has a “mental” label, they can be (and are being) forcibly coerced into inappropriate management regimes which have been shown to be harmful and which are at variance with their own experience as expert patients, a principle set out by Government in its publication “The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century published by the Department of Health in 2001.

It is also important to researchers in the biomedical community, because if a condition is designated as “mental”, there is no funding available to undertake any biomedical research (as is currently the case in this disorder), with the result that patients continue to be denied alleviation of their suffering.

Turning to your paean of praise for Professor Wessely, I believe this is misplaced. Whilst he is undoubtedly influential and is acclaimed within his own circle, in the wider sphere he is seen as showing a total lack of both understanding and compassion. There is now a vast amount of published evidence which shows that his beliefs are wrong, yet he persists in rejecting that evidence.

Are you aware that Professor Wessely has repeatedly been criticised in the mainstream literature for his bias, his methodological flaws, his lack of objectivity and his manipulating of others’ published research findings so as to make them appear to support his own conclusions when they do not? He has become notorious for ignoring the published work of those whose findings do not accord with his own beliefs, and also for his theories about the omnipresence of somatisation disorder. He has been severely criticised over his Gulf War studies by eminent experts in that field, including Professor Robert Haley in the US and Professor Malcolm Hooper in the UK.

It is indeed the case that for much of his career, Professor Wessely has been closely associated with both the MRC and Wellcome. You say that the MRC exercises “*the most demanding levels of peer-review*”: why, then, did a House of Commons Select Committee Report (The Work of the Medical Research Council Third Report of the Science and Technology Select Committee of the Session 2002-2003. HC 132. ISBN 021 500 896 0. March 2003) lambast the MRC for introducing misguided strategies, wasting research funding on projects of second rate quality and for mismanagement? MPs found that there were serious questions about the way the MRC has operated over the last few years. They warned that the MRC had failed to win the full confidence of both the public and the research community and that “*Something has gone badly wrong at the MRC. Our report shows why scrutiny of British science is so badly needed*”. Are you not aware of this unprecedented attack and damning judgment on the MRC ?

As for your enthusiasm for peer review, you must surely be aware of the current concern in the medical literature about how biased and unsatisfactory the peer-review process has been shown to be and the recognition that medical research is not well served by it. Are you not familiar with the concerns expressed in JAMA (Biomedical Journals Ponder the Failures and Remedies of Peer Review Joan Stephenson JAMA 2001;286:2) ? Are you also unaware of the Editorial in *Psychological Medicine* entitled “Publication bias and the integrity of psychiatric research” (Gilbody and Song, *Psychological Medicine* 2000;30:253-258) which supports the acknowledgement by medical science that the problem not only exists but is considerable. The Editorial is specific, stating “*this issue has been all but ignored in the sphere of mental health. Publication bias needs to be dealt with if psychiatry is going to become more ‘evidence-based’. The continued existence of publication bias represents the abuse of trust that patients give and is essentially a form of scientific misconduct. Compared to other specialities, psychiatry is likely to be especially prone to publication bias. A consequence is the danger that readers of journals are more likely to see studies showing results in a certain direction*”.

It is known that for many years, Professor Wessely has been one of the lead reviewers on “CFS”; please explain the validity of using someone whose entrenched views have led to rejection by UK editors of legitimate papers which support an organic pathoaetiology.

Professor Wessely is driving and dragging ME/ICD-CFS patients into the mental health agenda (which, of course, is where the research money is) and in the process he is denigrating and ignoring those who are physically very sick. In his studies he has never once looked at those with severe ME, a fact which is universally recognised. He does not have to prove his theories, only to publish them, for harm to result. ME/ICD-CFS is a massive and ever-growing problem and Professor Wessely’s answer is attractively simple to the cash-strapped NHS: just call it “somatisation disorder”, because that can be defined as a dysfunctional belief that a person is physically ill and then force patients to “modify” those beliefs by means of cognitive behavioural therapy. Under its various names, somatisation disorder has in the past been offered by psychiatrists as an explanation for illnesses such as diabetes, Parkinson’s Disease and multiple sclerosis before medical science discovered a clearly organic basis, and outside the discipline of psychiatry, somatisation is known to be a word which cloaks ignorance under the guise of wisdom.

You seem unduly proud that Professor Wessely has been awarded a Research Medal by the Royal College of Physicians: in more than 200 publications, what, precisely, has he discovered in his research and what is the sum conclusion of these prestigious papers? He has

“discovered” that ME does not exist; that CFS is not as classified by the WHO; that there is no such disorder as Gulf War Syndrome; that no-one is harmed by chemicals, and that those who were poisoned by aluminium sulphate in their drinking water in Camelford were not really poisoned (even though at least eight people died; 25,000 suffered serious health effects and 40,000 animals were affected). As Principal Investigator at the (new) Mobile Phone Research Unit at Kings College Hospital, doubtless he is soon to “discover” mobile phones have no biological consequences for human health other than the aberrant beliefs of those using them.

Through his prolific output Professor Wessely has introduced his personal beliefs into the UK medical literature and those beliefs are aimed at changing the perception of ME/ICD-CFS held by both medical and lay people. Through the shortcomings of the peer- review system, his personal beliefs have become medical doctrine, effectively turning patients into victims.

I would be grateful if you would address all the very valid points I have raised in both my letters. I look forward to receiving a reasoned and comprehensive reply.

Yours sincerely

The Countess of Mar

cc Diana Organ MP

The Chief Medical Officer for England and Wales

Institute Of Psychiatry At The Maudsley

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KING'S College LONDON

University Of London

8th September 2003

The Rt. Hon. Countess of Mar
House of Lords,
Westminster, W1

Dear Lady Mar,

Thank you for your letter of 2nd September 2003.

I note your concerns, but as I stated in my previous letter to you, I do not have any expertise in the nomenclature or classification of CFS/ME. It is thus inappropriate for me to enter into a debate about the matters you raise. These are issues for the experts to determine, using the best available scientific methods.

May I suggest that, if you have not already done so, you raise your concerns with the editors of the WHO Guide to Mental Health in Primary Care.

I am sorry I am unable to help you further.

Yours sincerely

Dr George Sz mukler
Dean

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Note from the MEActionUK editor:

It has been pointed out to me that Dr George Sz mukler and Clare Garrada (Professor Simon Wessely's wife) co-edited a book entitled "Mental Illness - A handbook for caregivers" by Ramsay R. Gerada C. Sz mukler G. Royal College of Psychiatrists 2001.

You can find this book on Amazon.com by clicking [here](#).

This might explain why Dr Sz mukler defended Professor Simon Wessely so fervently in his previous letter to the Countess of Mar. Of course it goes without saying that the very same Clare Garrada gets a mention in the acknowledgements page of the WHO Guide to Mental Health in Primary Care along with her husband Simon Wessely.

Click [here](#) for details.

It seems to myself and many others that we have a really close knit group of individuals here all propping each other up and forcing through a pre-set agenda. This agenda is of course fully supported by our largest ME charity Action for ME who now approve of the inclusion of

Chronic Fatigue Syndrome (and thus ME) within the pages of the WHO Guide to Mental Health In Primary Care.

If you would like to petition Action for ME as to why they approve of the inclusion of CFS/ME in the WHO Guide to Mental Health in Primary Care; an inclusion that allows the NHS Information Authority (amongst others) to falsely classify patients diagnosed as having ME/CFS as having a mental health disorder for the benefit of clinicians and healthcare professionals throughout the NHS, you can e-mail their Chief Executive Chris Clark [here](#).

Regards,

Stephen Ralph.

