Michael Sharpe Quotes

Margaret Williams

22nd March 2019

BACKGROUND

Professor Michael Sharpe

Michael Sharpe is heavily involved with the medical insurance industry, including UnumProvident. Unum's "**Chronic Fatigue Syndrome Management Plan**" dated 4 April 1995 (authored by Dr Carolyn L Jackson) is unequivocal: (i) "**Diagnosis: Neurosis with a new banner" (ii) "UNUM stands to lose millions if we do not move quickly to address this increasing problem".**

The incidence and prevalence of ME/CFS are known to be rising substantially. As long ago as 1994, UNUM reported that no other disease surpassed the rate of increase of ME/CFS. In order of insurance costs, ME/CFS came second in the list of the five most expensive chronic conditions, being three places above AIDS.

In addition to UNUM, insurance companies known to be involved in ME/CFS claims include Swiss Life, Canada Life, Norwich Union, Allied Dunbar, Sun Alliance, Skandia, Zurich Life and Permanent Insurance, and as re-insurers, the massive Swiss Re. These companies also seem to be involved in re-insurance: for example, Norwich Union uses Swiss Re as re-insurer, whose "CFS experts" include Michael Sharpe. This seems to mean that there is little hope of an ME/CFS claim succeeding, because both the insurers and the re-insurers all use the same group of psychiatrists to inter-refer claimants with ME/CFS.

Michael Sharpe was the lead author of the "Oxford Criteria" for CFS; these criteria specifically exclude those with neurological disease (and exclude the cardinal symptom of ME) but stipulate that psychiatric disorders are not to be excluded (A report – chronic fatigue syndrome: guidelines for research. JRSM 1991:84:118-121). These criteria have now been discredited by the US National Institutes of Health (NIH), who convened a "Pathways to Prevention" working group which on 16th July 2015 published its Report "Advancing the Research on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome". The Report is clear: *"Specifically, continuing to use the Oxford definition may impair progress and cause harm. Thus, for needed progress to occur we recommend that the Oxford definition be retired"* https://prevention.nih.gov/programs-events/pathways-to-prevention/workshops/me-cfs/workshop-resources#finalreport

QUOTATIONS from Professor Sharpe's published work on CFS/ME/Post-Viral Fatigue Syndrome

1991

Psychiatric Management of Post Viral Fatigue Syndrome M Sharpe
British Medical Bulletin 1991:47:4:989-1005

"Psychiatric management may be defined as the assessment and treatment of the mentally ill"

"Personality factors (attitudes, beliefs and thoughts) and behaviour have been shown to perpetuate disability"

"The use of extensive laboratory investigation may be psychologically harmful to the patient by reinforcing their beliefs about serious physical disease"

"Even if shown to be beneficial, (immunological) treatment is unlikely to be feasible on a wide scale because of cost"

"There is evidence that psychiatric treatment can reduce disability in CFS. In some patients it can be 'curative' ".

1991

Mania and recovery from chronic fatigue syndrome MC Sharpe BA Johnson
JRSM 1991:84:51-52

"Psychosocial factors may maintain disability**. Family members may reinforce beliefs and avoidance (of activity). We suggest that the clinical assessment should consider mood, beliefs, avoidance of activity and the role of the family"**

1994

The Chronic Fatigue Syndrome: A Comprehensive Approach to its Definition and Study.
K Fukuda S Straus M Sharpe et al *Ann Intern Med 1994:121:12:953-959*

"In clinical practice, no additional tests, including laboratory tests and neuro-imaging studies, can be recommended"

"Examples of specific tests (*which should not be done*) include serologic tests for enteroviruses; tests of immunologic function, and imaging studies, including magnetic resonance imaging scans and radionuclide scans (such as single photon emission computed tomography (SPECT) and positron emission tomography (PET) of the head"

"We consider a mental status examination to be the minimal acceptable level of assessment"

"We dropped all physical signs from our inclusion criteria".

1995

Chronic fatigue, chronic fatigue syndrome, and fibromyalgia Wessely S and Sharpe M.

In: Treatment of Functional Somatic Symptoms. Ed: Mayou R, Bass C and Sharpe M. (chapter 16): OUP 1995

On the issue of patients' organisations making medical research information available to members, Sharpe states: **"Such information may have a considerable and often unhelpful influence on patient attributions of illness".**

1997

Chronic Fatigue Syndrome: A Practical Guide to Assessment and Management Sharpe M Wessely S et al
Gen Hosp Psychiatry 1997:19:3:185-199

"The clinical problem we address is the assessment and management of the patient with a *belief* that he / she has a fatiguing illness such as CFS, chronic fatigue and immune deficiency syndrome (CFIDS) ---*CFIDS in fact stands for chronic fatigue and immune dysfunction syndrome* --- or myalgic encephalomyelitis (ME). **The patients who cause the greatest clinical difficulty are those with both severe symptoms and strong beliefs. The majority of patients believe that their symptoms are the result of an organic disease process. Many doctors believe the converse**

"It is particularly important to focus on factors which may be *perpetuating* the illness. A large number of somatic symptoms suggests a greater likelihood of psychiatric disorder. **A conviction of a *solely* physical cause for symptoms is the single most consistent predictor of poor outcome**

"Beliefs are probable illness-maintaining factors and targets for therapeutic intervention

"Many patients receive financial benefits and payments which may be contingent on their remaining unwell. Recovery may therefore pose a threat of financial loss

"Most sufferers are seeking confirmation of their own intuition that they are suffering from a particular condition, rather than reassurance that they are not

"**Abnormal physical signs should not be accepted as compatible with a diagnosis of CFS**

"Reports from specialist settings have shown statistically increased rates of abnormal results on tests for parameters such as antinuclear factor, immune complexes, cholesterol, immunoglobulin subsets and so forth. Their significance is for researchers rather than clinicians and we feel that testing for such variables is more likely to result in iatrogenic (*caused by doctors)* harm than good

"Many physicians are reluctant to make the diagnosis of CFS *(because of*) reinforcing unhelpful illness beliefs

"Patients need a diagnosis in order to organise their dealings with the world of benefits

"Perpetuating factors (*include*) reinforcement of sick role by mother and doctor

"An important task of treatment is to return responsibility to the patient for rehabilitation without inducing a sense of guilt

"It is usually possible to persuade these patients to try antidepressants"

"Disability systems and insurance agencies are sceptical about CFS. When asked to comment in benefits or insurance claims, we do not support claims for permanent disability until all reasonable efforts at rehabilitation have been tried."

1997

Chronic Fatigue Syndrome and Occupational Health A Mountstephen and M Sharpe
Occup Med 1997:47:4:217-227

"(The term myalgic encephalomyelitis) has been used to define a supposedly specific disease associated with viral infection….**the existence of ME…remains unestablished. Use of the term is best avoided"**

(ME as a specific syndrome has been classified since 1969 as a neurological disorder by the World Health Organisation; it was accepted as a nosological entity by the Royal Society of Medicine in 1978; it was recognised by the UK Department of Health as an organic disorder in November 1987; it is a matter of public record that the Minister of Health (Stephen Dorrell MP) confirmed that ***"ME is established as a medical condition"*** *on 16 August 1992, so it is difficult to know on what evidence these authors rely to support their statement that "the existence of ME as a specific syndrome remains unestablished").*

"The label of CFS avoids the connotations of pseudo-disease diagnoses such as ME"

"Patients' beliefs and behaviour are often a prominent part of the clinical presentation"

"Illness perpetuating factors are more important than predisposing or precipitating factors"

"Psychiatric assessment is recommended in *every case*"

"Few laboratory investigations are necessary"

"Important aspects are the individual's beliefs about their illness"

"Referral to 'specialists' should be avoided as they can entrench illness behaviour"

1997

Treating medically unexplained physical symptoms. Effective intervention available.
EDITORIAL: EDITOR'S CHOICE Richard Mayou Michael Sharpe.
BMJ 1997:315:561-562

"Chest pain, back pain, headache, muscular pains, bowel symptoms, breathlessness, dizziness and fatigue often remain unexplained after medical assessment. Such cases may be referred to as functional syndromes of chronic fatigue or as somatoform disorders"

"When symptoms are found not to result from 'genuine physical illness', they are often attributed to mental illness"

"This integrative approach (consists of) **identifying the principal factors that perpetuate illness, including misinterpretation of bodily sensations, abnormalities of mood and unhelpful coping behaviour".**

"The small but conspicuous group of patients who present with recurrent and multiple physical symptoms will be given co-ordinated care aimed at limiting unnecessary medical interventions".

1998

Cognitive Behaviour Therapy   Michael Sharpe
A Research Portfolio on Chronic Fatigue. Ed: Robin Fox; published by The Royal Society of Medicine for The Linbury Trust, 1998

"CBT helps patients to re-evaluate their beliefs (and) encourages them to change their behaviour"

"Change in the belief is an important factor in recovery".

1998

Doctors' Diagnoses and Patients' Perceptions: Lessons from Chronic Fatigue Syndrome
EDITORIAL   Michael Sharpe   *Gen Hosp Psychiat 1998:20:335-338*

"These patients want a medical diagnosis for a number of reasons. First, it allows them to negotiate reduced demands and increased care from family, friends and employer….In short, (a biomedical label) admits them to a bona fide 'sick role'. **Second, it may open the way for practical help in terms of financial and other benefits from government, employers and insurers"**

"Why are many physicians reluctant to provide a medical diagnosis? (Because) to make such a diagnosis, especially if it is suggested by the patient, may risk the censure of peers"

"For many patients, obtaining an acceptable diagnosis becomes their main preoccupation".

1999

Functional somatic syndromes: one or many?   S Wessely   C Nimnuan   M Sharpe
Lancet 1999:354:936-939

"Chronic fatigue syndrome is associated with worse disability than conditions such as heart failure"

"Many of these (functional somatic) syndromes are dignified by their own formal case definition and body of research"

"We have put forward the hypothesis that the acceptance of distinct syndromes as defined in the medical literature should be challenged"

"We propose an end to the belief that each different syndrome requires its own particular sub-specialist".

1999

ME. What do we know (real physical illness or all in the mind?)
Lecture given in October 1999 by Michael Sharpe, hosted by the University of Strathclyde

"In my lecture this evening, I would like to talk to you about myalgic encephalomyelitis (ME), also known as chronic fatigue syndrome or CFS (which) for convenience I will refer to as CFS"

"The conventional wisdom is that illnesses are made real when they are legitimised by a doctor's diagnosis"

"The vehemence with which many patients insist that their illness is medical rather than psychiatric has become one of the hallmarks of the condition"

"Purchasers and Health Care providers with hard pressed budgets are understandably reluctant to spend money on patients who are not going to die and for whom there is controversy about the "reality" of their condition (and who) are in this sense undeserving of treatment"

"Those who cannot be fitted into a scheme of objective bodily illness yet refuse to be placed into and accept the stigma of mental illness remain the undeserving sick of our society and our health service."

2000
Chronic Fatigue Syndrome (Myalgic Encephalomyelitis) Michael Sharpe
NETDOCTOR.CO.UK February 2000

"Special investigations such as brain scans do not help the diagnosis of this condition".

2000

Insurance Medicine. Chronic fatigue syndrome and its management. Dr Michael Sharpe, University of Edinburgh. Conference rapporteur: Ian Cox MA MRCP, Chief Medical Officer, Prudential UK, Reading. *JRCP 2000:34:394-396*

"Psychosocial factors are important in CFS. Prognostic factors include family factors and social factors"

"Social attitudes and differing health beliefs can slow down or even prevent a return to work and such beliefs are increasingly being promulgated through the media and doctors have to be aware of these issues".

2001

Interpretation of symptoms in chronic fatigue syndrome Dendy C Cooper M Sharpe M
Behaviour Research and Therapy 2001:39(11):1369-1380

"The tendency to interpret symptoms in terms of physical disease rather than emotion is potentially of clinical importance as it has been shown to predict a poor outcome"

"A cognitive model of ME/CFS has been proposed (Sharpe et al, 1991)"

"According to this model, the interpretation of symptoms predominantly in terms of physical illness, and not in terms of emotional states, plays a particularly important role in the maintenance of the disorder"

"Patients with ME/CFS may have had experiences of being told by others, including medical staff, that their symptoms are best explained by physical illness. It seems likely that such experience will contribute to the development of beliefs".

2001

Unexplained somatic symptoms, functional syndromes and somatisation: do we need a paradigm shift?

Michael Sharpe Alan Carson *Ann Intern Med 2001:134:9:2:926-930*

"It does seem that the neglect of the psychological impact can be harmful, for example, by suggesting to the patients that they are sick when they are not".

2002

The English Chief Medical Officer's Working Parties' report on the management of CFS/ME: Significant breakthrough or unsatisfactory compromise? Michael Sharpe *Journal of Psychosomatic Research 2002:52:6:437-438*

"In 1998, the UK Chief Medical Officer took the unusual step of commissioning a special working group (on CFS). What does it say?"

"Some recommendations are controversial. The first of these is about a matter as basic as what to call the illness. The report comes down on a compromise term CFS/ME"

"My own view has long been that the issues around CFS/ME are the same as those surrounding the acceptance and management of (patients) who suffer conditions that are not dignified by the presence of what we call disease".

2002

Clinical Review: ABC of psychological medicine: Functional somatic symptoms and syndromes Richard Mayou and Andrew Farmer, edited by Michael Sharpe and Alan Carson *BMJ 2002:325:265-268*

"Some common functional symptoms and syndromes (include) Chronic fatigue (myalgic encephalomyelitis)"

"Perpetuating factors: Doctors may also contribute to this by…unwittingly increasing fear of disease (such as by excessive investigation)

"The provision of disability benefits can also be a financial disincentive"

"The more somatic symptoms a person has, the less likely it is that these symptoms reflect the presence of disease"

"Antidepressants are of value whether or not the patient is depressed".

2002

Clinical Review: ABC of psychological medicine: Organising care for chronic illness

Michael Sharpe David Wilks *BMJ 2002:325:480-483*

"Patients generally regard fatigue as important, whereas doctors do not"

"Predisposing factors include being female"

"Perpetuating factors include physical inactivity (and) emotional disorders"

"Other factors such as immunological abnormalities are not of clinical value"

"A preoccupation with medical causes seems to be a negative prognostic factor"

"Perpetuating causes (are) excessive inactivity, unhelpful beliefs, avoidance of activity"

In online correspondence dated 11th August 2002, Michael Sharpe wrote: "*I do not represent the profession of psychiatry…I am currently not even doing research on CFS/ME – so no funds squandered there*"; this was deemed to be disingenuous and on 30th August 2002 Michael Sharpe acknowledged: "*I am one applicant for a large multicentre trial…into the management of CFS that is being considered for funding by the MRC";* Sharpe and his co-Principal Investigators were subsequently granted £5m for the PACE trial, which started in 2004.

2002

What should we say to patients with symptoms unexplained by disease? 'The number needed to offend'

Jon Stone, Alan Carson, Michael Sharpe et al *BMJ 2002:325:1449-1450*

"Most doctors make a diagnosis and offer treatment to patients whose symptoms turn out to be unexplained by disease"

" 'Hysteria' was the traditional term and is still sometimes used"

"We call for the rehabilitation of 'functional' as a useful and acceptable diagnosis for physical symptoms unexplained by disease".

2002

Functional Symptoms and Syndromes: Recent Developments Michael Sharpe

In: Trends in Health and Disability 2002, Report of UNUM Provident Insurance Company

"It is becoming increasingly clear that the problem of patients who have illness that is not clearly explained by disease is a large one"

"There is a great deal of confusion about what to call such illness. A wide range of general terms has been used including 'hysteria', 'abnormal illness behaviour', 'somatisation' and 'somatoform disorders' "

"There is strong evidence that symptoms and disability are shaped by psychological factors"

"Especially important are the patients' beliefs and fears about their symptoms"

"Possible causal factors in chronic fatigue syndrome:

"Psychological: personality, disease attribution, avoidant coping style.

"Social: information patients receive about the symptoms and how to cope with them; this information may stress the chronicity and promote helplessness. Such unhelpful information is found in 'self-help' books. Unfortunately doctors may be as bad.

"Obstacles to recovery:

"The current system of state benefits, insurance payment and litigation remain potentially major obstacles to effective rehabilitation"

"As the authority of medicine to define what is a legitimate illness is diminished, increasingly consumer oriented and privatised doctors will collude with the patient's views that they have a disabling and permanent illness"

"It will be imperative that health and social policy address this problem"

"Both health services and insurers now need to take a more positive approach".

2004

Somatoform disorders --- new approaches to classification, conceptualization and treatment

Winfried Rief Michael Sharpe

Editorial: Journal of Psychosomatic Research 2004:56:387-390

"Every medical specialty has its own syndrome of 'medically unexplained' or 'functional' somatic symptoms. Fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, pelvic pain syndrome and non-cardiac chest pain are just some examples"

"Abnormal illness behaviour was described as seeking verification of a medical diagnosis by multiple doctors ('doctor-shopping'), urging doctors to do unnecessary investigations, inability to go working, and many others"

"Modern psychiatry is based on the concept of psychopathology. That is, patients are assumed to have 'mental disease' "

"Hence, somatoform disorders serve both medicine and psychiatry by providing a disposal for the patients who would otherwise challenge the theoretical models upon which practice is based".

2004

Somatoform disorders: a help or hindrance to good patients care? Michael Sharpe Richard Mayou

British Journal of Psychiatry 2004:184:465-467

"The value of somatoform diagnoses is often taken simply to indicate a need to minimize access to medical care".

2005

The Science of the Art of Medicine   Michael Sharpe
Inaugural Lecture, University of Edinburgh, 12 May 2005

In his inaugural lecture, Sharpe (who then held a Personal Chair in Psychological Medicine and Symptoms Research) spoke on "functional medicine" and how to treat diseases with "no pathology".

Sharpe highlighted medicine's 'blind spot' in dealing with symptoms that are not expressions of disease, including patients with chronic fatigue syndrome or ME.

Sharpe's topics (taken directly from his own notes) included indicators of his intransigent beliefs about ME/CFS, for example:

"It is apparent that the attitude of patients suffering from this chronic state must be changed…"

"The knowledge that experience has shown that certain sensations have resulted from certain activities must be replaced by a conviction that these efforts may be made without harm".

2006

Commentary: Symptoms not associated with disease: an unmet public health challenge
Jane Walker, Michael Sharpe & Simon Wessely. *International Journal of Epidemiology 2006: March 1.*

"Modern medicine is based on pathological diagnosis. But many patients present with symptoms that lack any identifiable pathology".

"How should their 'medically unexplained' complaints be understood and categorised?"

"Within psychiatry medically unexplained symptoms have been classified under the somatoform disorder label".

"One approach is to treat them as if there is organ symptom pathology and to give 'medical' diagnoses….Another is to assume that they represent the physical presentation of a psychological or psychiatric illness…(mental illness in somatic form)".

"This approach has the potential to lead us to a better understanding of the prevalence of such symptoms unbiased by consulting behaviour".

"These syndromes have a number of associated non-symptom factors in common: female gender, high levels of health anxiety (and) increased symptom reporting".

"Our current classification system and medical-system-based management of these patients must change. **Using our current classification system such patients will continue to be referred to multiple specialist clinics"**

"This paper reminds us of the value of…research in highlighting the shortcomings of categorising patients to fit with medical specialisation".

2006

Occupational Aspects of the Management of Chronic Fatigue Syndrome: A National Guideline October 2006
NHS Plus Evidence based guideline. External Assessors: Professor Michael Sharpe & Professor Peter White.

The Report states: "Limitations of the Literature Review: The two external assessors are experts in the field of CFS and they indicated that they were content that all relevant research had been identified in the review".

Under "Conflicts of interest", the NHS Plus Guideline states: "none declared", yet the two external assessors (Sharpe and White) were long-time medical advisers to the insurance industry, so there was a blatant failure to declare such obvious conflicts of interest.

This was a serious issue, because there is written evidence that Professors Peter White and Michael Sharpe appeared to have been less transparent than was required of them.

On 20th November 2008 the Department of Health confirmed (in writing) in relation to the NHS Plus Guideline about Professors White and Sharpe: "I can confirm that the guideline contributors gave written confirmation that they had no conflicts of interest".

Since it was known that Professors White and Sharpe did have significant conflicts of interest and since any such conflicts had been denied by them, representations were made questioning why their known conflicts of interest had been denied.

Following these representations, on 23rd December 2008 a remarkable revelation was made – in writing – by Dr Ira Madan:

"The Department of Health have asked me to investigate your concern that… the two external assessors, Professor Michael Sharpe and Professor Peter White, had conflicts of interest whilst involved in the production of the guideline. I can confirm that I was aware of the potential for competing interests that you have stated. The roles that Professor White and Professor Sharpe have undertaken for the agencies and companies that you stipulate (i.e. the DWP and the medical and permanent health insurance industry) were in the public domain prior to the publication of the NHS Plus guideline. I am content, as the Director of that guideline, these potential competing interests did not in any way influence the synthesis of the evidence or the guideline recommendations".

There is thus written confirmatory evidence from Dr Ira Madan that Professors White and Sharpe did have what she referred to as "competing interests" that were undeclared, but that she was "content" about the situation.

This illustrates how the normal rules of independent peer review and conflicts of interest are suspended when it comes to the "evidence-base" for CBT/GET in people with ME/CFS, because in relation to the NHSPlus Guidelines, two researchers were allowed to sit in judgment on their own publications, with the prior knowledge and permission of Dr Ira Madan.

Furthermore, they were not required to make conflict-of-interest declarations, even though their conflicts were known about by Dr Madan. This is not peer-review as the rest of the scientific world understands it.

Quotations from the full report include the following:

"In the past 20 years, the medical profession has increasingly come to believe that symptoms of individuals with CFS are not readily explained by recognisable organic disease".

"Poor outcome was predicted by membership of a self-help group; being in receipt of sickness benefit at the start of treatment".

It concluded that the two treatments for which there is the greatest weight of evidence are CBT and GET and its "Key priority for implementation" states: **"Ill health retirement should be deferred until CBT/GET has been explored".**

NHS Plus issued three leaflets promoting its Policy Document, all claiming to be "evidence-based"; they are intended for employers, employees and healthcare professionals.

The Policy Document itself and the three promotional leaflets all fail to present a balanced view of ME/CFS and reflect unequivocal support for the psychosocial model of the disorder.

All failed to state that the correct WHO classification for ME/CFS is neurological.

The leaflet for healthcare professionals stated:

"This leaflet summarises the findings of a review of the scientific evidence on the occupational management of CFS…It summarises the evidence-based guidance on how to support individuals back into, and to remain in, work".

"The perpetuation of CFS may be attributed to an individual's response to an illness".

"Factors may include inactivity; deconditioning, weakness and fatigue brought on by excessive rest after an acute viral illness; inappropriate avoidance of activity (and) fears about the condition itself".

The "Management" is CBT and GET which are "supported by good quality evidence", but the leaflet concedes that: "Not everyone responds well to CBT", stating **that factors which may limit its effectiveness include "excessive focus on bodily symptoms and taking …disability-related benefit during treatment".**

It continued: **"Patients who are still working should be advised to stay at work, even if they feel tired".**

2007

Revising the Classification of Somatoform Disorders: Key Questions and Preliminary Recommendations
Kurt Kroenke, Michael Sharpe, Richard Sykes *Psychosomatics 2007:July-August: 48:4*

"Somatoform Disorders are a diagnostic category for which major revisions seem warranted….A large-scale revision is planned".

"The Conceptual Issues in Somatoform and Similar Disorders (CISSD) was launched several years ago … to stimulate a multidisciplinary dialogue about the taxonomy of somatoform disorders and the medical diagnoses of functional somatic syndromes eg. irritable bowel syndrome; **chronic fatigue syndrome**, fibromyalgia".

"Patients often resist having somatic problems labelled as a psychiatric disorder, with the consequent stigma and negative financial implications".

"Terms such as 'functional', 'medically unexplained' and 'psychosomatic' are currently less satisfying to many patients than the diagnosis of a particular medical disorder".

"Multi-system diseases usually have objective manifestations…and are not commonly misdiagnosed as somatoform disorders".

2008

Chronic fatigue syndrome   Michael Sharpe
Psychiatric Aspects of General Medicine: Medicine 2008:36:9:452-454

"Illness perpetuating factors include inactivity, a fear of making oneself worse and belief that the illness is permanent…. Management should be directed at the perpetuating factors".

"CFS shares symptoms, aetiological factors and treatment response with other so-called 'functional somatic syndromes' ".

"Ensure it is clear that you accept the reality of the patient's symptoms and that you do not think they are imagined or 'all in the mind' ". (This clearly advocates duplicity and deception of patients by the clinician).

2009

Neurology out-patients with symptoms unexplained by disease: illness beliefs and financial benefits predict
1-year outcome   M. Sharpe, A Carson et al. *Psychological Medicine 2009:40(4):689-698*

"We …aimed to determine predictors of poor subjective outcome for new neurology out-patients with symptoms unexplained by disease one year after the initial consultation".

"In the multivariate analysis, **the only strong independent predictors of a poor outcome were the patients' beliefs in expectation of non-recovery, non-attribution of symptoms to psychological factors, and the receipt of health related financial benefits at the time of the initial consultation".**

"The finding that being in receipt of financial benefits…predicted poor outcome will perhaps not come as a surprise to many clinicians…Hence it is possible that payment consequent on having symptoms and disability acts to perpetuate them".

"The finding of an association of poor subjective outcome with specific beliefs and being in receipt of health-related financial benefits **in patients with symptoms unexplained by disease**…may point the way to a greater understanding of the psychological and social mechanisms that determine poor outcome".

2011

Disability, distress and unemployment in neurology outpatients with symptoms 'unexplained by organic disease' A Carson, C Warlow, M Sharpe et al *JNNP 2011:82:810-813*

Of note is the fact that Michael Sharpe -- one of the PACE Trial Principal Investigators -- co-authors papers with Professor Charles Warlow who, at the time of the PACE Trial, was Complaints Ombudsman for The Lancet where the misleading results were published, making it impossible to seek his intervention in The Lancet's failure to address the formal complaints submitted (because he was conflicted).

"We know that one-third of neurology out-patients have symptoms…that are not explained by recognised 'organic' disease".

"But are these patients really ill?...Are such symptoms actually associated with disability…and is this reflected in their…receipt of disability-related state financial benefits?"

2012

Healthcare costs incurred by patients repeatedly referred to secondary medical care with medically unexplained symptoms: a cost of illness study Burton C, Sharpe M et al
Journal of Psychosomatic Research 2012:72(3):242-247

"Some patients are repeatedly referred from primary to secondary care with medically unexplained symptoms. We aimed to estimate the healthcare costs incurred by such referrals".

"The repeated referral of patients with MUS to secondary medical care incurs substantial healthcare costs".

2014

Medically unexplained symptoms including chronic fatigue syndrome can be accurately identified and treated
Research Excellence Framework 2014 Impact Case Studies Submitting Institution: University of Edinburgh
Team led by Alan Carson and Michael Sharpe

"Up to 1 in 300 people in the UK have CFS".

"In 2011, Sharpe and colleagues published the first definitive randomised controlled study (n = 641) showing superior efficacy of CBT for CFS …and the inefficacy of the very widely recommended (at the time) intervention of 'pacing' at 52 weeks follow-up (the PACE trial)".

"By showing the benefits of accurate identification and targeted treatment of chronic fatigue syndrome, UoE research has influenced worldwide medical practice….Guidelines and policy debate have resulted in improved patient treatment, with associated economic benefit".

"These medically unexplained symptoms…cost the NHS £14K per annum per patient. The cost to the UK economy is up to £3.5 billion per annum for CFS alone".

“The UoE challenged the once popularly held view that CFS is an organic disorder”.

“The work has been presented at international meetings and published in high-impact journals with global reach accompanied by UoE and Medical Research Council press releases”.

“The work has also led specifically…and directly to changes in what is considered best clinical practice”.

“The work has fed into the development of the International Classification of diseases (ICD-11) and the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-V)”.

These statements should be compared with what Professor Michael Sharpe said on Australian Radio on 18th April 2011 when speaking about the £5 m PACE trial:

“What this trial wasn’t able to answer is how much better are these treatments than really not having very much treatment at all” (http://www.abc.net.au/rn/healthreport/stories/2011/3192571.htm).