ME/CFS & FM and the Problem With "Multi-Disciplinary Health Services Clinics"

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In recent years, disability insurers have increasingly adopted a new approach in respect of disability income claims based on conditions such as Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome (ME/CFS) and Fibromyalgia (FM). This approach involves the use of "Health Services Clinics".

The Health Services Clinics (HSCs) used by disability insurers are typically privately-owned and privately-run operations which provide "multi-disciplinary" or "inter-disciplinary" assessments of disabled individuals. These assessments usually include medical, behavioral and psychiatric evaluations. In addition, the HSCs provide "multi-disciplinary" treatment programs that are said to be based on the results of the assessments and, the HSCs claim, will result in significant improvement in the degree of disability.

A common scenario is as follows: the disability insurer refers the claimant for a "multi-disciplinary" assessment by a HSC. Typically, the claimant is already in receipt of disability benefits and is approaching or at the point where the contractual definition of "Disabled" is about to change from one defined in terms of the claimant's ability to do his or her own occupation to one defined in terms of ability to do virtually any occupation. In directing the claimant to submit to the HSC assessment, the disability insurer relies on the terms of the insurance policy which obligate the claimant to comply with insurer-ordered medical assessments or examinations. The HSC assessment typically involves an internist, a physiatrist, a psychiatrist, a psychologist, perhaps a kinesiologist, and especially in cases of FM, a rheumatologist. The assessment usually takes several days – perhaps over several weeks- and may involve a visit to the claimant's home. A complete psychiatric assessment is taken, including the patient's history since childhood and a listing of all possible stressors in the period just prior to, and during, the period of disability.

In the vast majority of cases, the HSC assessment produces a comprehensive, multi-paged report, which often contains at least the following primary conclusions:

1. There is no clearly-definable, objectively-demonstrable underlying disease process or pathology to account for the claimant's ongoing discomfort and disability. Put another way, the degree of discomfort and disability claimed by the patient is in excess of that which can be accounted for solely on the basis of a clearly-definable underlying disease process or pathology.

2. The claimant's definable medical status is such that there are no specific activities which would be medically contra-indicated – in the sense that such activities would place the claimant at increased risk of harm or damage by virtue of engaging in such activities.

3. The claimant shows evidence of a psychological condition or abnormality which is contributing to his or her claimed discomfort and disability, and which should be addressed by cognitive behavioral therapy. A number of specific stressors can be identified in the claimant's life – past and present- which typically produce the psychological condition or abnormality discerned. (In addition, there is often a finding that the claimant has poor "sleep hygiene", which is causing ongoing physical and emotional tiredness; and which should be addressed by altered sleep habits.)

4. The claimant is a candidate for a comprehensive multi-disciplinary treatment program, which can be provided by the HSC itself. This treatment program will involve cognitive-behavioral therapy, pharmacological intervention, and general physical re-conditioning. Through participation in this treatment program, the claimant, within four to six months, will very likely realize a significant improvement in his or her level of functioning and will be able to return to work, as well as resume many other activities lost since the onset of the disability.

Following the completion of the assessment procedure by the HSC and the production of the assessment report, the claimant is directed by the disability insurer to participate in the treatment program recommended by the HSC. The claimant has little choice in the matter because failure to participate in the program will be seen by the disability insurer as non-compliance with the claimant's obligations under the disability insurer's policy and will result in termination of the claimant's disability benefits.

In the majority of cases, the "multi-disciplinary treatment program" provided by the HSC consists of little more than a graduated exercise program. Typically, within four to six months following the commencement of the treatment program, the claimant is directed to commence a rehabilitative return-to-work program.

Analysis

The approach outlined above (hereinafter the "HSC Approach") is based on dubious premises and gives rise to erroneous conclusions. In addition, the HSC Approach outlined above is inappropriate and in many cases could be harmful to individuals disabled by ME/CFS and FM.

The fundamental premise of the HSC Approach to the treatment of ME/CFS and FM appears to be that in most cases of chronic disability, the initiating disease process or pathology has resolved, but "non-disease" factors or variables have taken over and become the primary source of the patient's discomfort and disability. The majority of these non-disease factors, it seems, are psychological; and thus fall under the inclusive label of "illness behaviour". Additionally, existing conditions such as dysthemia, depression, anxiety, etc., may have pre-disposed the patient to illness behaviour. Physical de-conditioning (attributable to the initial disease and/or the subsequent illness behaviour) and disturbed sleep, are other non-disease variables seen by proponents of the HSC Approach as contributing to false disability.

Because conventional medicine has no definitive diagnostic procedure for ME/CFS or for FM, and because these illnesses, so far, have no definable and objectively-demonstrable underlying disease pathology, and, further, because they often seem to develop following an illness such as the flu, or a traumatic accident such as a car crash, ME/CFS and FM fit neatly into the premise or theory underlying the HSC Approach. It is not at all surprising that the HSC assessment, which utilizes conventional diagnostic techniques and procedures, finds no clearly-definable, objectively-demonstrable underlying disease process or pathology to account for the patient's ongoing discomfort and disability. Also, where there is no definable underlying disease pathology, it is easy to conclude that various treatment modalities are not "contra-indicated"; i.e., the patient will not cause harm to himself or herself by virtue of engaging in any particular activities.

The fact that conventional diagnostic techniques do not find a clearly-definable, objectively-demonstrable disease process or pathology in patients suffering from ME/CFS or FM does not mean that the patient does not experience real and debilitating pain and discomfort that is physiological as opposed to psychogenic. Historically, this has been the case with numerous diseases or syndromes. There was a time when multiple sclerosis had no "clearly-definable, objectively-demonstrable underlying disease process or pathology" and was thought to be largely psychosomatic. We now know that MS is a serious and disabling physiological illness.

A major difficulty in the diagnosis – and indeed the treatment – of ME/CFS and FM is that each case may not be homogenous in origin. While medical science still has much to learn about the etiology of ME/CFS and FM, enough is presently known to establish that these conditions are physiologically-based and not psychological conditions. Given this knowledge, to find on the basis of conventional diagnostic procedures that ME/CFS and FM sufferers have no underlying organic disease process or pathology, is to advance an erroneous conclusion. Further, to state, on the basis of that erroneous conclusion, that the patient's definable medical status is such that there are no specific activities which are medically contra-indicated, is not only to advance a further erroneous conclusion – but perhaps an unhealthy one as well. It is well-documented that certain activities can exacerbate the symptomatology associated with ME/CFS and FM and prolong a patient's recovery.

By relying on the results of conventional diagnostic procedures, the HSC Approach incorrectly diminishes the effect of ME/CFS and FM and excludes these conditions from consideration as independent causes of disability. This is a serious flaw in the HSC Approach. Any treatment approach which virtually dismisses a patient's ME/CFS and/or FM as a major cause of the patient's discomfort and disability, cannot be expected to produce a valid treatment program.

Further, having found that there is no objectively-demonstrable physiological disease process to account for the patient's ongoing discomfort and disability, the HSC Approach has opened the door to the finding that the apparent cause of the patient's disability is largely psychological (e.g. illness behaviour, depression, anxiety, poor sleep

habits, etc.). Reasoning of this sort incorrectly sees*results* of the patient's chronic disability as *causes.* Many ME/CFS and FM sufferers experience reactive or secondary depression or dysthemia as a result of being chronically disabled. Further, it is well-known that ME/CFS and FM adversely affect the ability of the sufferer to obtain undisturbed and restorative sleep.

To summarize, the problems in the HSC Approach can be stated as following:

- relying on the lack of evidence (as determined by basic conventional diagnostic procedures) of a physiological disease process or pathology to conclude that there is no organic condition causing the patient's discomfort and disability (and to play up the role of non-disease factors such as "illness behaviour"
- relying on the lack of evidence of an physiological disease process or pathology to conclude that no specific activities are medically "contra-indicated";
- concluding that the patient's disability can be attributed primarily to psychological causes, and that the presence of outside stressors is diagnostically significant, when, firstly, such stressors are ubiquitous in present-day life and, secondly, given the chronic disability of the patient, it is to be expected that he or she will develop reactive psychological conditions or abnormalities; and,
- concluding that a treatment program consisting primarily of a graduated exercise program will bring about improvement of a degree sufficient to allow the patient to return to work.

Finally, it is arguable that the HSC, in carrying out both the assessment *and* the treatment program, has a serious conflict of interest. Clearly, insofar as the HSC stands to make more money if the claimant participates in the HSC's treatment program, the HSC has a pecuniary interest in the outcome of the assessment it conducts. Discussion of this topic, however, is perhaps best reserved for another, separate article.

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