Chronic Fatigue Syndrome

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CFS - A History

- **1880's** - Charcot - *Hysteria* - always females, non-explained conditions, faints - seen as a phenomenon
- **1869** - Beard - *Neurasthenia* - nervous exhaustion, fashionable, seen in high social groups, stress of high achievement, rest cure became fashionable, theories about 'nervous energy', 'trendy' illness
- **Early 20th Century** - Freud - *Psychological* - seen as unfashionable, working class 'problem', theories of causation, led to epidemics of fatigue
- **1956** - Ramsay - *Royal Free Disease* - Health workers all suffered, not patients. ???viral infection/phenomenon/mass hysteria
- **1980's onwards** - Myalgic Encephalomyelitis - Chronic Fatigue Syndrome - high achievers again, acceptable, fashionable, not imaginary, takes place in many sociological situations, theories of cause are the environment/chemicals/immune system - 'fashionable' theories

CFS - What is it?

- Fatigue is a common & normal human experience

  Fatigue is a part of both physical & mental disease - very common. Many people go to their GP complaining of fatigue - don't necessarily have ME
- Only a minority of people with chronic fatigue believe that they have ME
- Syndrome or disease??

  A syndrome is a well recognised group of syptoms or phenoemena brought together by way of a pathological process. Doctors can try to force patient's into pre-determined criteria for diagnosis of ME, expect patients to meet all criteria or else not confirm diagnosis
- Suggested causes are subject to a range of influences

  No actual unifying pathology - Doctors have to consider

  differences from the patient's pattern of normal behaviour

Decision Process - Claims

- Form and refine a range of expectations:-
  - 'Normal' behaviour of fatigue
  - Physical & psycological illness investigated, diagnosed or treated by GP
  - Ability to handle key life abilities (look at everything a person does - ADL's)
  - Compare claimant's statement and the activities of insured occupation
  - Ascertain GP reaction - ? Rule out 'normal' case or psycological situation
- Build picture which is consistent by consensus and credible
  - Identify physical & psycological illness - make enquiries
  - Life is 'difficult'

Some Claims Anecdotes.....

“When fatigued people cannot face the difficult realities of life the fatigue is a more comfortable place than day-to-day reality”

Examples

- Young doctor, high flyer throughout education - started pre-registration year in hospital and couldn’t cope - ‘fatigued’? Seen as 1st failure in life - a burning psycological issue - not resolve until issue addressed
- Male in 50’s, ‘fatigued’ when divorcing as now living with new partner and her 2 daughters who did not acknowledge that he existed - issue again not addressed

Evidence Collection - Claims

- Evidence is difficult to collect - tend to go to GP/consultant - BUT - challenge their thinking if necessary….
- History of present condition, nature & extent of physical signs?
- Have other cases of CFS been experienced and what investigations were conducted?
- Mental Health issues identified?
- Functional limitations & functional restrictions defined?
- What part/parts of occupation are restricted?
- How is the condition managed?
- What are the patient's expectations?
- Reasons why different from the norm?
- Gaps in evidence must be identified
- Who approaches, what do they ask?
- Evaluation in the home brings invaluable evidence if properly interpreted

RANGE OF EXPECTATIONS IS FUNDAMENTAL

Decision Process -Underwriting

- History of CFS - likely good or bad prognosis???

Good Prognosis

- Clear precipitating event - ? Connection with glandular fever in some cases
- No psycological symptoms in the past
- Short duration
- Improvement seen with treatment

Bad Prognosis

- No clear precipitating event
- Background of complex social issues
- Long duration
- Static or deteriorating
- Dismissal of any psycological factors in causation or maintenance
- Over-reliance on rest
- Belonging to self-help group(s)

Underwriting - Conclusion

Chronic Fatigue Syndrome is not life-threatening. It is likely to be associated with long-term sickness absence

(Income Protection concerns)

Look for good prognostic factors and a symptom-free period.

Questions

- **How do you classify the difference between limitations and restrictions?**
- Limitations are physical actions that you cannot do - grasp etc, restrictions are actions that you shouldn’t do - epilepsy & driving.

- **Surveillance is widely used at claims stage - thoughts on surveillance being used at underwriting/application stage?**
- Not considered in past - use of questions to draw information on the ‘meaty’ issues - look for prolonged fatigue and subtle clues in disclosures

- **Looking at a ‘best-case’ scenario e.g. a case with no precipitating cause, what terms seem reasonable?**
- Difficult to exclude. If a ‘clean’ episode in history and long period with no problems, individual circumstances and terms need to be considered - no rule of thumb can be quoted.

Questions - contd.

- **Is there figures regarding likely recovery percentages?**
- No - some self-help groups quote a rule of thirds:-

  1/3 - Get better }
  1/3 - Make significant functional recovery } Suspect reality
  1/3 - Don't recover - severe cases }

- **Is there a period of time beyond which recovery is seen as unlikely?**
- After 4 years may consider that no further recovery likely. Intensive therapy can improve prognosis.