



Charitable tax no. (BN) 89183 3642 RR001
ISSN 1205-786X

Quest

Quest #57: January/February 2003

ATTENTION: All Patients, Doctors, Lawyers, and Support Group Leaders

Please help us spread the word that the Canadian ME/CFS Clinical Working Case Definition, Diagnostic and Treatment Protocols is now published in the Journal of Chronic Fatigue Syndrome and can be purchased from Haworth Press as follows:

Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols (Journal of Chronic Fatigue Syndrome, Volume 11, Number 1, 2003) is available for US \$14.95 per copy plus \$5.00 Shipping and Handling. To order, contact The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580 USA. Telephone in US/Canada: (800) 429-6784, Telephone outside US/Canada: (607) 722-5857, fax: (607) 771-0012, email: orders@haworthpressinc.com
Online: <http://www.haworthpressinc.com/store/product.asp?sku=4958>

May 12 - National ME/CFS Awareness Day Projects

We are asking that everyone help us:

1. Alert doctors and lawyers to this document and give them the information needed to purchase a copy. If possible purchase an extra copy for your doctor.
2. Support Groups may wish to fundraise in order to purchase copies for the doctors of your members and/or the doctors in your community.
3. Contact your local media and ask that they write an article or have a blurb on TV about the document for ME/CFS Awareness Day. We will provide you with a press release upon request. Please include that the information on how to order the document is on the website of the **National ME/FM Action Network** <http://www.mefmaction.net>

Accolades and Support for the ME/CFS Clinical Working Case Definition, Diagnostic and Treatment Protocols

Dr. Ellie Stein, MD FRCP(C) Alberta, Canada: " I have now received all 6 copies that I ordered of the guidelines (ordered extra so I can educate my colleagues). I am very pleased with the paper, it really validates much of what I believe and have read and they avoided sliding down the CBT/GET

slope. Very impressive. I have already quoted Appendix 12 (my personal favorite) in one letter for a patient. "

Maryann Spurgin, PH.D, ME Society of America, U.S.A: "This case definition is a vast improvement over the 1994 CDC Fukuda criteria. The Fukuda criteria makes 'fatigue' a compulsory symptom but downplays and makes optional post-exertional sickness and other cardinal symptoms. Because of this, the Fukuda criteria has led to tremendous misunderstanding in research, clinical care, and treatment protocols by fostering the selection of patients with chronic fatigue and fostering the view that exercise is an appropriate therapeutic approach.

"In sharp contrast, the new Canadian clinical case definition specifically selects patients who worsen with exercise. The clinical definition makes it very clear and compulsory that in order to meet the diagnostic criteria, the patient must become symptomatically ill after exercise (this is termed 'post-exertional malaise'), and must also have neurological, neurocognitive, neuroendocrine, dysautonomic (for example, orthostatic intolerance), and immune manifestations. That is, worsening with exercise, and many symptoms other than fatigue, must be present for a patient to meet the diagnostic criteria. This case definition will go a long way to help distinguish ME/CFS patients from chronic fatigue patients, depressed patients, and patients with other illnesses who do improve with exercise. The Canadian definition specifically states that patients 'become worse after exercise rather than better.' This counters the view being put forward by persons such as Dedra Buchwald and Simon Wessely who hold that the disease is a behavioral problem leading to deconditioning. Unfortunately, such work does not even give patients the now-respectable status of a psychiatric illness, but rather refers to vague terms like 'perception' and 'interpretation of symptoms'. The new case definition, much of which is backed by research, is a strong counter statement to the view held by Buchwald and Wessely.

"We encourage patients and patient groups to urge acceptance of this case definition in government documents so that appropriate research into the pathophysiology of the disease can be implemented and inappropriate, possibly harmful treatments will not be fostered. This case definition strengthens the ability to select and diagnose ME/CFS by sharpening the definition. We hope that patients will promote this definition by taking it to their primary care physicians, donating copies to medical libraries, and contacting their local media.

"We would like to thank Lydia Neilson and her group, The National ME/FM Action Network, the physicians from Canada and the USA, and the Journal of Chronic Fatigue Syndrome, all of whom worked together to bring this case definition to fruition."

The Myalgic Encephalomyelitis Association of Ontario: "Congratulations to the **National ME/FM Action Network** for achieving this remarkable consensus document published in the Journal of Chronic Fatigue Syndrome Volume 11 (1) by Haworth Press, New York. A special thanks to Marj van de Sande for the tremendous amount of work and energy involved for her to coordinate the project. We can all hope that this publication will increase having our voices heard on the severity of the symptoms of our illness, bring clarity and understanding of ME/CFS and stimulate more research. Thank you Lydia for having the fortitude to keep focused on achieving the completion of this project. Congratulations again and job well done!!"

**MYALGIC ENCEPHALOMYELITIS/CHRONIC FATIGUE SYNDROME – Clinical
Case Definition and Treatment Protocols – Impact on Assessing
Occupational Disability**

Hugh Scher, Barrister & Solicitor

Recent publication of the clinical case definition and diagnostic and treatment protocols, which was reached on consensus of a panel of Canadian, American and European experts on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), represents a significant achievement in the understanding of this illness, and its effects on the daily lives of those affected by it. The panel's experts include specialists in internal medicine, physiology, cardiology, microbiology, immunology, infectious diseases, haematological pathology, sleep disorders, psychiatry and family practice. The multifaceted, multidisciplinary approach of the consensus document will benefit clinicians involved in the diagnosis, assessment, and treatment of patients with ME/CFS.

The clinical case definition and diagnostic and treatment protocols have significant implications for the manner of assessment and adjudication of disability benefits' claims. Firstly, the clinical case definition sets out specific criteria for the diagnosis and assessment of ME/CFS, which are more encompassing than the CDC criteria that were developed to standardize research. The clinical definition includes the prominent features of severe, prolonged fatigue, post-exertional malaise, sleep and neurocognitive dysfunctions, pain, and manifestations of dysfunction involving the endocrine, immune, and central and autonomic nervous systems.

Secondly, the consensus document makes it clear that there is no known cure or magic bullet for the treatment of ME/CFS. The publication sets out guidelines for management and treatment programs. The paramount role of the primary treating physician in directing rehabilitation efforts is stressed. It emphasizes that the patient's impairments/limitations and activity boundary fluctuations are part of the pathophysiology of the illness and they must be respected and reflected in any management, treatment, or rehabilitation program. The management section sets out a series of practical life-style practices and self-help therapies that may assist in alleviating some of the often severe and debilitating symptoms associated with the illness and ameliorate the patient's ability to cope with their functional impairments.

As post-exertional malaise is a hall-mark feature of ME/CFS, the expert panel stresses the importance of a thorough patient evaluation with special attention to risk factors and optimizing medical management before considering any exercise program. The expert panel emphasizes that great care must be taken in prescribing any exercise program, as severe or prolonged exacerbation of symptoms will worsen symptoms and can cause the patient to relapse. Therefore, exercise programs must be individualized to the patient's abilities/limitation and total illness burden, and attempt to ameliorate the patient's function in daily living activities.

The concrete set of recommendations provided will serve as a useful tool for medical assessors, lawyers and adjudicators involved in the assessment and adjudication of entitlements related to occupational disability and benefits. The expert panel highlights the importance of a realistic functional assessment of disability based on the consistency of subjective complaints of patients over time and the consistency of subjective and objective findings of treating clinicians. The document serves to debunk many myths about ME/CFS and the methods used to assess disability in these patients. Such methods are often based on the erroneous premise that the patient's disability and symptoms are illegitimate, without known etiology, incapable of objective assessment, and thus incapable of restricting patient functions from activities of daily living, work or other related functions. Further, the expert panel documented the negative effects of many methods presently being used, especially by disability adjudicators, such as Functional Abilities Evaluations (FAE), Graduated Exercise Therapy (GET), Cognitive Behavioral Therapy (CBT), work-hardening programs, and one-shot functional assessments. The expert panel, in its collective wisdom and experience, believes such programs must be critically assessed as they may be inappropriate and contrary to pathophysiology of the illness, as well as the well-being of most ME/CFS patients.

The clinical case definition, and diagnostic and treatment protocols reflect a culmination of modern research and clinical experience. It would be expected that application of the principles set out in the clinical case definition and treatment protocols will serve to enhance clinicians' understanding of this

illness, and will assist patients in their efforts to cope with the impact of the disorder and its symptomology. The consensus document will also serve to provide benchmarks for disability benefits adjudicators and rehabilitation providers in a manner consistent with sound research, clinical experience and sound medical practice. In time, it would be expected that this enhanced understanding of ME/CFS and its functional effects will lead to an enlightened clinical approach to ME/CFS with a view to improving patient function, enhancing quality of life and addressing the underlying medical symptomology and root causes of the disorder. In this regard, appropriate assessment and rehabilitation will hopefully serve to enhance patient opportunities to overcome occupational disability, implement appropriate accommodations within the workplace to address the needs and requirements of disabled employees. This will lead to a more enlightened adjudication process as regards disability benefits' entitlements based on a principled approach grounded on the best available research, rather than conventional methods.

Note: Hugh Scher is a partner in the law firm of Scher & De Angelis where he practices civil litigation and administrative law with a focus on insurance, employment, and human rights law especially in the area of disability rights. The author is available to answer questions and provide consultation on issues regarding ME/CFS. He also serves as counsel to the National ME/FM Action Network and Fibromyalgia Society of Ontario and has represented dozens of individuals with Fibromyalgia and ME/CFS in disputes with long-term disability insurers, the Canada Pension Plan, employers and Revenue Canada. Mr. Scher contributed to the occupational disability section of the consensus document.

Scher & De Angelis Professional Corporation, Barristers & Solicitors, Suite 210, 69 Bloor Street East, Toronto, Ontario, Canada, M4W 1A9 Telephone (416) 515-9686, Facsimile (416) 969-1815
Email: hugh@scherdeangelis.com Web: <http://home.interlog.com/~scherde/>

INFORMATION FOR ME/CFS PHYSICIANS - Cognitive Function in ME/CFS
Prepared from the medical literature (July 2001)
Eleanor Stein MD FRCP(C)
Psychiatrist, Burke Institute for the Rehabilitation of Chronic Illness
Suite G100 Holy Cross Centre 2210 - 2nd St. SW
Calgary Alberta T2S 3C3 Canada
Phone (403) 802-1772 Fax (403) 802-1762

Subjective cognitive dysfunction is a complaint of over 80% of patients with CFS and is a diagnostic criteria in all 4 of the extant working definitions.

What we know: Based on a thorough literature review it is agreed that persons with CFS (various definitions) show:

1. normal global intellectual functioning
2. normal receptive functioning
3. normal ability to focus and sustain attention for low effort tasks but reaction times and information processing are slowed
4. impaired concentration and memory for tasks requiring greater mental effort, less benefit from cueing, increased sensitivity to interference and slowed processing which limits elaboration of information during encoding
5. normal ability for verbal and non verbal conceptualization.

The cognitive deficit in CFS is not a structural one in any particular part of the brain. It is a functional disorder of information processing speed and efficiency. Emotional factors influence subjective report of cognitive difficulty, whereas their effect on objective performance remains uncertain. (Moss-Morris & Petrie, 1996; Tiersky et al, 1997)

Neuropsychological Findings:

- Cognitive deficits can be elicited more easily after aerobic exercise (LaManca et al, 1998;Blackwood et al, 1998).
- Cognitive changes are not due to psychiatric comorbidity (Johnson et al, 1996;Kane et al, 1997;Blackwood et al, 1998;Vercoulen et al, 1998;Michiels et al, 1996;Joyce et al, 1996;Michiels et al, 1999). DeLuca et al have found that cognitive impairment is greater in the absence of psychiatric diagnosis (DeLuca et al, 1997).
- Even groups who in other papers posit a psychological cause for CFS have found objective cognitive changes. eg. Vercoulen et al found that 80% of test subjects could be correctly classified as CFS or control based on the cognitive test results. Joyce et al (Wessely's group) found deficits in many aspects of function.
- Cognitive dysfunction in CFS is not due to lack of effort during testing (Blackwood et al, 1998) (Schmaling et al, 1994).
- Cognitive dysfunction in CFS is not due to somatic overconcern (Vercoulen et al, 1998).
- Christodoulou et al report that CFS patients with failing scores (> 2SD below the mean) on verbal memory were more functionally disabled however the correlation between subjective and objective disability is still debated (Christodoulou et al, 1998).

Brain Imaging Findings:

- SPECT cerebral blood flow studies of persons with CFS show decreased blood flow in several key areas such as frontal lobes and brain stem which are different from both healthy controls (Barnden et al, 2001;Costa et al, 1995) and depressed subjects (Schwartz et al, 1994;Fischler et al, 1996). PET scan studies have reached similar conclusions (Tirelli et al, 1998).
- QEEG has also shown several abnormalities in brain function in CFS and neurophysiological differences between subjects with CFS and depression (Flor Henry et al, 2001).

Tests which most commonly discriminate CFS from controls:

- Any test measuring functioning before and after exertion
- Psychomotor speed - Finger Tapping Test (Halstead 1947), slower and decreasing speed across trials
- Memory - Selective Reminding Task (Rey 1964) delayed recall and long term storage
- Auditory processing speed - PASAT (Stuss et al 1987)
- Attention - Digit span forwards and backwards (Wechsler 1955), Trail making test parts A&B (Reitan & Davidson 1974)

Conclusions

As a group persons with CFS have measurable cognitive impairment which is made worse by physical exertion and cannot be attributed to comorbid conditions or attitudes. In individual patients cognitive deficits are difficult to prove with neuropsychiatric testing since there are rarely premorbid test results with which to compare. Never the less, findings which are out of keeping with known levels of premorbid functioning and decreased functioning after aerobic exercise are consistent with a diagnosis of CFS. Healthy controls and persons with depression generally do better on neuropsychiatric tests after exercise.

References

- Barnden,L., Kitchener,M., Casse,R., Burnet,R.,Delfante,P., & Kwiatek,R. Regional cerebral bloodflow in chronic fatigue syndrome (CFS). Unpublished presentation 2001.
- Blackwood,S.K., MacHale,S.M., Power,M.J., Goodwin,G.M., & Lawrie,S.M. (1998) Effects of exercise on cognitive and motor function in chronic fatigue syndrome and depression. *Journal of Neurology, Neurosurgery & Psychiatry*, **65**, 541-546.
- Christodoulou,C., DeLuca,J., Lange,G., Johnson,S.K., Sisto,S.A., Korn,L., & Natelson,B.H. (1998) Relation between neuropsychological impairment and functional disability in patients with chronic fatigue syndrome. *Journal of Neurology, Neurosurgery & Psychiatry*, **64**, 431-434.

- Costa,D.C., Tannock,C., & Brostoff,J. (1995) Brainstem perfusion is impaired in chronic fatigue syndrome. *QJM*, **88**, 767-773.
- DeLuca,J., Johnson,S.K., Ellis,S.P., & Natelson,B.H. (1997) Cognitive functioning is impaired in patients with chronic fatigue syndrome devoid of psychiatric disease. *Journal of Neurology, Neurosurgery & Psychiatry*, **62**, 151-155.
- Fischler,B., D'Haenen,H., Cluydts,R., Michiels,V.,Demets,K., Bossuyt,A., Kaufman,L., & De Meirleir,K. (1996) Comparison of 99m Tc HMPAO SPECT scan between chronic fatigue syndrome, major depression and healthy controls: an exploratory study of clinical correlates of regional cerebral blood flow. *Neuropsychobiology*, **34**, 175-183.
- Flor Henry,P.I., Lindl,J., Morrison,J., Pazderka-Robinson,H., & Kolas,Z. Chronic fatigue syndrome versus depression. 2001. ref Type: Unpublished Work
- Johnson,S.K., DeLuca,J., Diamond,B.J., & Natelson,B.H. (1996) Selective impairment of auditory processing in chronic fatigue syndrome: a comparison with multiple sclerosis and healthy controls. *Perceptual & Motor Skills*, **83**, 51-62.
- Joyce,E., Blumenthal,S., & Wessely,S. (1996) Memory, attention, and executive function in chronic fatigue syndrome. *Journal of Neurology,Neurosurgery & Psychiatry*, **60**, 495-503.
- Kane,R.L., Gantz,N.M., & DiPino,R.K. (1997) Neuropsychological and psychological functioning in chronic fatigue syndrome. *Neuropsychiatry, Neuropsychology, & Behavioral Neurology*, **10**, 25-31.
- LaManca,J.J., Sisto,S.A., DeLuca,J., Johnson,S.K.,Lange,G., Pareja,J., Cook,S., & Natelson,B.H. (1998) Influence of exhaustive treadmill exercise on cognitive functioning in chronic fatigue syndrome. *American Journal of Medicine*, **105**, 59S-65S.
- Michiels,V., Cluydts,R., Fischler,B., Hoffmann,G., Le Bon,O., & De Meirleir,K. (1996) Cognitive functioning in patients with chronic fatigue syndrome. *Journal of Clinical & Experimental Neuropsychology*, **18**, 666-677.
- Michiels,V., de,G., V, Cluydts,R., & Fischler,B. (1999) Attention and information processing efficiency in patients with Chronic Fatigue Syndrome. *Journal of Clinical & Experimental Neuropsychology*, **21**, 709-729.
- Moss-Morris,R. & Petrie,K.J. (1996) Functioning in Chronic Fatigue Syndrome: Do illness perceptions play a regulatory role? *British Journal of Health Psychology*, **1**, 15-25.
- Schmaling,K.B., DiClementi,J.D., Cullum,C.M., & Jones,J.F. (1994) Cognitive functioning in chronic fatigue syndrome and depression: a preliminary comparison. *Psychosomatic Medicine*, **56**, 383-388.
- Schwartz,R.B., Komaroff,A.L., Garada,B.M., Gleit,M., Doolittle,T.H., Bates,D.W., Vasile,R.G., & Holman,B.L. (1994) SPECT imaging of the brain: comparison of findings in patients with chronic fatigue syndrome, AIDS dementia complex, and major unipolar depression. *AJR Am.J Roentgenol.*, **162**, 943-951.
- Tiersky,L.A., Johnson,S.K., Lange,G., Natelson,B.H., & DeLuca,J. (1997) Neuropsychology of chronic fatigue syndrome: a critical review. *Journal of Clinical & Experimental Neuropsychology*, **19**, 560-586.
- Tirelli,U., Chierichetti,F., Tavio,M., Simonelli,C., Bianchin,G., Zanco,P., & Ferlin,G. (1998) Brain positron emission tomography (PET) in chronic fatigue syndrome: preliminary data. *American Journal of Medicine*, **105**, 54S-58S.
- Vercoulen,J.H., Bazelmans,E., Swanink,C.M., Galama,J.M., Fennis,J.F., van,d., Meer,J.W., & Bleijenberg,G. (1998) Evaluating neuropsychological impairment in chronic fatigue syndrome. *Journal of Clinical & Experimental Neuropsychology*, **20**, 144-156.

Disability Benefits and You

George Cameron-Caluori

This article was reprinted from the Winter, 2002 issue of Canadian Disability.

Proposed disability tax credit amendments withdrawn

The federal government spends about \$400 million per year in tax assistance to about 450,000 Canadians eligible to receive the disability tax credit (DTC). That may explain why, when the Tax

Court of Canada awarded a DTC to Ray Hamilton because of difficulties he had in procuring and preparing food, the government opted to appeal this decision to the Federal Court of Canada. Unfortunately, when they lost this next decision, they reacted by deciding to change the law.

Hamilton has celiac disease – a permanent intolerance to gluten in his diet. He has to find and buy gluten-free foods, use additional time reading labels, check regularly with product manufacturers to ensure no cross contamination, and spend further additional time at home preparing food, adapting recipes, and cooking.

In March 2002, the Federal Court agreed that Hamilton was entitled to a tax credit. The Income Tax Act (s.118) allows for a tax credit for persons with a severe and prolonged impairment who, due to their medical condition, must spend an inordinate amount of time performing a basic activity of daily living.

The Minister argued that the term “feeding oneself” in section 118 may include food preparation where there is a marked restriction in one’s physical ability. But to provide tax relief for the work required in procuring safe foods is to “stretch the words of the statute beyond their meaning,” no matter how severe the medical condition is or limited the food options are. The government argued that allowing a tax credit based on care taken in selecting foods, would be allowing a claim based on personal taste and market availability.

The Hamilton decision is important to any person who can establish that they suffer an exceptional, severe food allergy that forces them to spend an inordinate amount of time procuring and preparing suitable food.

On August 30 of this year, the federal Department of Finance, responding to the Hamilton decision, announced that it was considering amendments to the Income Tax Act to restrict “feeding oneself” to the act of putting food in one’s mouth and “dressing oneself” to putting on or removing one’s clothes. The intent was to ensure that the tax credit remains available to individuals who are severely restricted in their daily activities and not to reduce the government’s support. Unfortunately, however, the amendments would effectively limit the broader and compassionate application anticipated by the Federal Court.

The response from people with disabilities, disability associations and advocates, other stakeholders, and some MPs was intense and immediate. In late November, the controversial proposal was withdrawn, replaced by a round of new consultations to develop a revised proposal. The deadline for submissions on this consultation process is January 17, 2003.

While this request for consultation is encouraging, the work has in fact already been done. In March, 2002 the Standing Committee on Human Resources Development and the Status of Persons with Disabilities released Getting It Right for Canadians: The Disability Tax Credit. The report was based on hearings that included various disability associations, advocacy groups, Canada Customs and Revenue Agency (CCRA), and of course, the Department of Finance. The Committee unanimously confirmed the disability community’s views regarding the unfair practice of the CCRA in administering the tax credit and recommended reviewing the administrative process.

One wonders why they are trying to re-invent the wheel. Nonetheless, I encourage every interested party and person with a disability to make submissions. Write the Department of Finance with your experiences regarding qualifying for the tax credit and appealing decisions to deny. Send your comments to: Tax Policy Branch, 140 O’Connor Street, Ottawa K1A 0G5; credit@fin.gc.ca.

This is your government. They seem to be listening now, so make your voice heard.

George Cameron-Caluori is a consultant in Regulatory Law Administration who represents people with disabilities before CPP Review Tribunals and Pension Appeals Boards. George can be reached at gcamcal@istar.ca or 1-888-734-7776.

Inherent Bias Against Insurance Claimants

Recently, a doctor requested that the Health Professions Appeal and Review Board of Ontario review a decision of the Complaints Committee of the College of Physicians and Surgeons of Ontario concerning a complaint made by a patient about an Independent Medical Examination (IME) and his subsequent report. The Health Professions Appeal and Review Board is the regulatory body that oversees 22 professional colleges, including the College of Physicians and Surgeons. In its decision, the Committee of the College of Physicians and Surgeons had decided to caution the doctor, in person, because the written report contained improper language—"loaded, pejorative vocabulary", words such as "cunning" and "malinger" when describing the patient .

After an extensive review, in March 2003, the Health Professions Appeal and Review Board (HPARB) ruled that the College decision was reasonable. Further, HPARB ruled that this matter should be returned to the College of Physicians and Surgeons for further investigation and consideration. A new decision with reasons addressing the allegation of whether this doctor has demonstrated "an inherent bias against insurance claimants in general" is to be decided upon.

In upholding the College censure regarding pejorative language, HPARB took into consideration a telephone conversation between this doctor and the College investigator in which the doctor stated there are only three kinds of patients:

- Patients with nothing wrong with them who are "pulling the wool over everyone's eyes".
- Patients with no problem who think they have a problem. These patients actually believe that there is something wrong with them, even though there is not.
- Patients with a minor problem who have exaggerated this problem into something much bigger than it is.

When the College investigator pointed out to this doctor that there are patients who have something wrong with them who are not trying to "pull the wool over anyone's eyes" are not "exaggerating" but rather who have real and significant problems, the doctor responded by laughing.

After the College completes its investigation of this doctor for inherent bias against insurance claimants in general, we will report their decision.

Please, if you have been requested to attend an IME by a private insurance company, CPP, or WSIB, fill out our confidential Registry Submission Form so that we can continue to track those IME doctors whom patients feel are performing inaccurate and biased reports and send us a copy of your letter of complaint to the appropriate regulatory college. Place a cc. National ME/FM Action Network at the bottom of your letter so the College is aware that our organization is tracking their decision. We would be pleased to help with letter writing for those needing help because of cognitive problems or fatigue.

All across the country, the **National ME/FM Action Network** are making gains in raising awareness about this serious problem because of the efforts of patients willing to complain about this injustice.

To receive a copy or copies of the simple, confidential, 7 question Registry Submission Form, please Contact: **Mary Ellen**, Manager of Special Projects, Phone or fax: **(905) 831-4744**

Mail: **P.O. Box 66172, Town Center Postal Outlet, 1355 Kingston Rd., Pickering, ON., L1V 6P7**

Email: marye@pathcom.com

Or download the Form from our website at

www3.sympatico.ca/me-fm.action/medexam.html

NATIONAL DOCTORS' ROSTER - Addition

David R.W. Bayley, Bsck., N.D.

Delbrook Naturopathic Medical Centre Inc

Suite 100 - 3711 Delbrook Ave.

North Vancouver, BC V7N 3Z4

Tel. **(604) 986-9191**

NATIONAL LAWYERS' ROSTER - ADDITION: - Initial Consultation - Free

DEVRY, SMITH & FRANK LLP

Contact: **Esther Cantor**

95 Barber Green Rd., Suite 100, Toronto, ON M3C 3E9

Phone: **(416) 446-5840** Fax: **(416) 449-7071**

JEWELL MICHAEL & ABRADOVICH

Contact: **René Clonfero**

390 Bay St., Suite 700, Toronto, ON M5H 2Y2

Phone: **(416) 862-7020** Fax **(416) 862-2135** E-mail: rclonfero@canlegal.com

Special Assistance Available Web: www.canlegal.com -

CAPP SHUPAK

Contact: **Marilyn Shupak**

2 St. Clair Ave. W., Suite 1703, Toronto, ON M4V 1L5

Phone: **(416) 323-1116 Ext. 308** Fax **(416) 323-0697**

E-mail: mshupak@cappshupak.com Web: www.marilynshupak.com

JANE MUKONGOLO B.A., LL.B.

Contact: **Jane Mukongolo**

510 - 1001 Bay Street, Toronto, Ontario M5S 3A6

Phone: **(416) 929-6821** Fax: **(416) 929-4253** E-mail: jane@mytorontolawyer.com

Civil Litigation Web: www.mytorontolawyer.com and www.ontariodivorces.com

BEAMENT GREEN Lawyers

Contact: **John R. Reed**

#204 - 47 Clarence St. Ottawa, ON K1N 9K1

Phone: **(613) 241-3400** Fax **(613) 241-8555**

E-mail: jread@beament.com Web: beament.com

PIERCE LAW GROUP

Contact: **Lawrence E. Pierce**

#850 - 475 West Georgia Street, Vancouver, BC V6B 4M9

Phone: **(604) 681-4434** Fax **(604) 681-9142**

ME/FM matters, LTD and personal injury

E-mail: info@piercelawgroup.com Web: bcdisabilitylaw.com

Takes Cases on percentage and finances disbursements

Books/Newsletters/Videos, etc.

"WHAT YOUR DOCTOR MAY NOT TELL YOU ABOUT PEDIATRIC FIBROMYALGIA:

A Safe New Treatment Plan for Children - By: **Dr. Paul St. Amand, M.D., and Claudia Craig Marek.**

Cost: **\$19.95** - Available in book stores.

OUR WORLD:

DIFFICULTY READING: REGRESS TO LOOKING AT PICTURES

NAUSEA: FUN WITHOUT THE MERRY-GO-ROUND RIDE

Resource Books

QUEST COLLECTION" BOOK - FIVE YEARS: By popular request, **the National ME/FM Action Network** has published an easy to read book consisting of a **collection** of important articles which have appeared in our 'QUEST' newsletters over the years. For easy reference, these articles have been grouped into sections, according to their focus i.e. medical, legal etc. We have kept the **cost** of the book to a minimum of **\$20.00** each which includes shipping and printing. Please make **your cheque payable to the National ME/FM Action Network** and let us know how many copies you would like.

TEACH-ME - Sourcebook for Teachers. We are proud to announce that the hard-copy of **our Sourcebook for Teachers**, an educational resource book full of information and teaching strategies for teachers and parents of children and youth who have ME/CFS and/or FM, is now available. Price **\$22.00** (includes S & H) – Discount on bulk orders. Cheques payable to the **National ME/FM Action Network**. Please also see our youth and parents' pages on our website at: www.mefmaction.net

LEGAL/RESEARCH PACKAGE - Medical and Legal Information on ME/CFS and/or FM, a resource for lawyers, advocates, doctors and patients. Please make **cheque payable to Marj van de Sande** in the amount of **\$25.00** (our Director of Education) to cover photocopying, postage charges etc., **151 Arbour Ridge Circle NW, Calgary, AB T3G 3V9 - Tel/Fax: (403) 547-8799. E-mail: mvandes@telus.net**

<p>MEMBERSHIP: \$25.00 per year which includes bi-monthly newsletters – Payment can be made by CHEQUE, VISA or MASTERCARD - NATIONAL ME/FM ACTION NETWORK, 3836 Carling Ave., Nepean, ON K2K 2Y6 Canada – Tel/Fax: (613) 829-6667 – E-mail: ag922@ncf.ca - Web: http://www.mefmaction.net</p>

COPYRIGHT NOTICE: The National ME/FM Action Network newsletter "QUEST" is published every two months. Its contents are © 2003 by the National ME/FM Action Network, EXCEPT where authors of articles are indicated. These items are copyrighted by the authors and written permission must be obtained from the author in order to reprint them. Other articles may be reproduced by other non-profit publications as long as copyright notices are included and items are clearly attributed to the NATIONAL ME/FM ACTION NETWORK, citing its name, address, telephone number and website.

DISCLAIMER: The NATIONAL ME/FM ACTION NETWORK serves as a clearing house for information on Myalgic Encephalomyelitis / Chronic Fatigue Syndrome and Fibromyalgia. Some of the information contained herein is intended to help patients and their physicians make informed decisions about their health. However, the NATIONAL ME/FM

ACTION NETWORK does not dispense medical advice or endorse any specific medical hypothesis or product and assumes no responsibility for any treatment or action undertaken by its readers.