Chronic pain sits at the right end of a distribution curve that includes intermittent pain in the bell-shaped middle. As such, it remains a symptom that challenges medical efforts to treat it. Unfortunately, unnamed symptoms cannot satisfy impairment and disability scales and other numerical classifications. To ask, have you had it before, and upon a positive answer to say, well, you have it again, as the old joke has it, would be flippant. It fails to explain why the pain for which no organic cause can be identified presents itself. Physicians and their patients are discomfited when no name can be sum up their symptoms. As a consequence, a series of nonsensical terms have been attached to such presentations, turning symptoms into a remunerative industry feasting on fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity syndrome, and many instances of repetitive strain syndrome, and combinations thereof [1]. These diagnoses imply an etiology, often fastening on some prior trauma or series of traumas, that enrich plaintiff lawyers and their experts, impoverish the social and insurance support systems, clutter the offices of a wide range of health-related professionals, dispirit those so diagnosed, and create a pall of victimisation in families and communities. Totally subjective and defined by circular reasoning, fibromyalgia and its bedmates subvert clinical medicine. Indeed, the concept fails the test of science proffered by Sir Karl Popper and approvingly cited in the Daubert decision accepted by the United States Supreme Court: it lacks falsifiability [2]. Denial of the strong psychogenic component reflects our culture’s discomfiture with the influence of the mind on the body; many consider such an attribution pejorative. Ultimately, a classification dependent on the demonstration of a number of tender points at sites usually more sensitive than adjacent areas in everyone, lacking any accompanying sign that qualifies neither as cause or effect and that requires statistical manipulation to become a differentiating feature, has created an industry that subverts logic and evidence-based medicine. As Falstaff states in another context, “A good wit will make use of anything. I will turn diseases into commodity.” [3]

My mail recently brought an unsolicited copy of a book [4] and of a magazine [5] devoted to fibromyalgia. The book, under erudite quotations heading the chapters, presents an ever expanding set of symptoms purporting to describe sufferers from fibromyalgia. It erroneously states that the World Health Organisation (WHO) accepts the diagnosis (our Expert Advisory Panel on Chronic Degenerative Diseases explicitly rejected it, and published this rejection in the official book, Low Back Pain Initiative [6]) and repeats the canard that the multitude of symptoms (called siliconosis by some, but basically conforming to the authors’ expanded definition of fibromyalgia) attributed to silicone breast implants and now roundly disproved might still be a reaction to the silicone. It reflects the post hoc ergo propter hoc thinking that defines the defense of the term by the dwindling number of proponents (and I cannot believe that a prestigious publisher, Oxford University Press, was gullible enough to publish this guide). Its definition of fibromyalgia is boundaryless and merges imperceptibly with those not afflicted.

The magazine is a blatant exploitation that, among other matters, teaches the reader how to simulate the unverifiable catalog of symptoms. There is no medicine approved by the FDA for the treatment of “fibromyalgia”, nor should there be (treatment of chronic pain would be an appropriate indication). That does not prevent this promotional publication, with an editorial board culled chiefly from the fibromyalgia advocates, from being filled with advertisements promising relief, usually in couched terms. Unfortunately, the Arthritis Foundation’s magazine, Arthritis Today, too frequently features articles and advertisements also validating fibromyalgia. And, unbelievably, the mail also brought an announcement of a conference trumpeting “latest 21st
...century medical advances in the diagnosis & treatment of fibromyalgia, chronic fatigue syndrome and related illnesses”, (sic) sponsored by the patient advocacy organisations for these so-called syndromes and co-sponsored by “the Healthy Foundation”, a vitamin promoter. Another unsolicited parcel contained copies of the Journal of Chronic Fatigue Syndrome, already in Volume 10, Journal of Musculoskeletal Pain, in Volume 9, and Number 1, of Volume 1, of the Journal of Whiplash and Related Disorders, together with a catalogue listing many other publications of similar tenor. This publishing barrage further promotes these questionable concepts and diagnoses.

The clinician confronted with these symptoms cannot and should not deny their existence, but efforts at remedying the complaint are frustrated by the current support system. When the Social Security Administration redefined disability, I served on the subcommittee, headed by the late Mary Betty Stevens, dealing with musculoskeletal issues. We declined to list fibromyalgia (or fibrositis, as it was then commonly called) among the compensable disorders, but of late, under Congressional pressure, this, too, has often been granted disability status and compensation. How did we arrive at such a pass? That people “all people” often have aches and pains is a given; that these are usually self-limited though at times recurrent, and often dismissed by those who have them as insignificant is usual. Perhaps an over-the-counter remedy will be resorted to; it can be obtained without learned intermediaries so no label is attached to the pain and the individual can recover. As Hadler has posited, when doctors are consulted and diagnose fibromyalgia, a sickness is created out of ordinary life experiences [7]. To help in studying pain syndromes, a committee of the American College of Rheumatology codified the essentials in the diagnosis for research purposes by creating classification criteria [8]. These have been misused ever since as diagnostic criteria, despite protests by the Chairman of this committee [9] and legitimate skepticism by others [10,11, 12], including some who had identified some of the clinical features in the first place [13]. The eighteen sites of tenderness on pressure are a thin reed upon which to hang a diagnosis; the various patient advocacy groups have helpfully published a diagram of their location so that members can say “ouch” convincingly and grimace when these are pressed. The acknowledgement of sensitivity at these sites and a history of widespread pain present at least three months are all that is required for the diagnosis of fibromyalgia. The many recently published studies purporting to find biochemical or anatomical changes more often in fibromyalgia than in others are meaningless; they confirm only that those on the far end of the curve are more likely to have features that may well be responses to pain rather than causative, and as these are present to some degree at all points of the scale, they prove nothing [14–16].

When the criteria were promulgated, the chairman intended to present a construct that would help physicians communicate with each other more effectively in the hopes that the pitiful patients (who, indeed, voiced these complaints but had no objective findings to account for them) would be treated benevolently and not subjected to endless “and expensive” work-ups. But the seeming legitimisation of the syndrome has led to disastrous legal and financial consequences, especially when fibromyalgia has been attributed to trauma. In a vain attempt to stem the avalanche, the chairman pleaded for sanity to return to the issue, reserving the diagnosis as a shorthand classification criterion rather than the disease or syndrome “... patient organisations ... treating physicians, and, often ... research scientists” seem to consider it to be a (“well-accepted disease” at that) [17].

A consensus conference brought together an international group of experts at the University of British Columbia in Vancouver in 1994 [18]. The issues were discussed, with contributions by activists who champion the concept and its compensation and skeptics who question the validity of both. Once again, Wolfe produced the report, to which all present had contributed. The statement recognised that no investigation had properly addressed the question whether the diagnosis could be “false manipulated by the claimant.” It also recognised that “... where compensation is widely available, illnesses similar to (fibromyalgia) have been shown to increase in apparent prevalence ... then to fall when compensation availability declines.” Indeed, this happened in Australia, in a well-studied “epidemic” [19]. Health questionnaires were mentioned approvingly, but “... almost all assessments used ... rely on self-report, where validation is difficult or impossible” and concluded that “(n)o studies have specifically addressed validity and reliability of any of the ... assessments ... in the work place, compensation or injury setting.”

Disquieting is the catalogue that enlarges the concept: “... fatigue, sleep disturbance, mood disturbance, headache, irritable bowel symptoms, among others. Tenderness at sites not specified by the ACR criteria does not exclude the diagnosis” [17] (sic). The group seemed to agree that the majority of patients have chronic symptoms that wax and wane but most are able to work. Treatment should emphasise a comprehensive approach and eschew dependence on drugs. A fitness regimen would help.

This seeming agreement rapidly came under attack from a small minority of participants, who are advocates of the concept of fibromyalgia as a disease or syndrome that trauma can trigger, and a peripatetic few roam the country testifying to the disability that warrants compensation for the claimant. This malign concept has gained a foothold in many social systems, especially in Europe, where a liberal compensation system rewards it with extra vacation days and rehabilitation support. A Norwegian survey of young women found an annual incidence of 583/10000 [20] including all levels of severity. The annual cost in countries that compensate for...