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PAUL BOSTON

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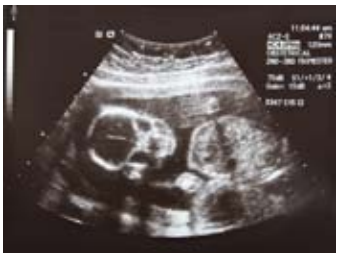

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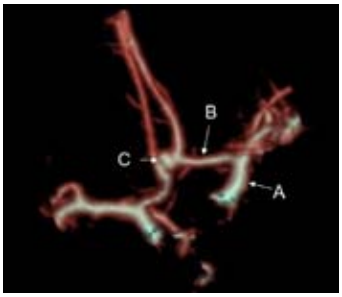

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MORTEN SKOVDAL

PICTURE OF THE WEEK

Fifteen year old Florance with her grandmother, whom she lives with and cares for in Kenya. The picture is part of an exhibition of photographs and drawings by children who care for relatives dying of AIDS in Africa at the London School of Economics and Political Science, London, until 2 June.

The launch of the exhibition was attended by British children who act as carers for sick parents. Dr Morten Skovdal, research fellow at the Institute of Social Psychology, said, "We found that many of the children identify the benefits of being a young carer and take great pride in their emotional maturity and the life skills they gain through their caring."

See www2.lse.ac.uk

bmj.com/archive
Editorial : Who cares for young carers? (*BMJ* 1994;308 :733)

THE WEEK IN NUMBERS

22% Overall reduction in all cause mortality associated with β blocker use in chronic obstructive pulmonary disorder
(Research, p 1068)

2nd Trimester of pregnancy that is considered safest for women to travel
(Clinical Review, p 1074)

170 000 Number of nasogastric feeding tubes supplied to the NHS each year
(Practice, p 1079)

80-85% Proportion of primary subarachnoid haemorrhages caused by ruptured saccular aneurysms
(Practice, p 1082)

QUOTE OF THE WEEK

"Inadequate homes are a waste of energy, a health hazard, and a shameful relic for their part in fostering persistent, avoidable, social inequity"

Keith B G Dear and Anthony J McMichael, College of Medicine, Biology and Environment, Australian National University, Canberra, on the scourge of cold homes
(Editorials, p 1035)

QUESTION OF THE WEEK

Last week we asked, "Should the United Nations appoint a representative to investigate violations of medical neutrality in countries like Bahrain?"

81% voted yes (total 203 votes cast)

This week we ask, "Is the peer review system in crisis?"

bmj.com/archive News: Experts deny claims that peer review system is in crisis (*BMJ* 2011; 342:d2858)

bmj.com Cast your vote

EDITOR'S CHOICE

Who should define disease?

Those who argue that it's too hard to find experts who don't have industry ties are just not looking hard enough

Last year an international panel of professional societies changed the definition of gestational diabetes. The blood glucose threshold for diagnosis was substantially lowered, more than doubling the number of women with the diagnosis. It will now encompass almost one in five pregnancies.

In his feature investigation this week (p 1054), Ray Moynihan highlights this as just the latest example of how the definitions of common conditions are being broadened, so much so that by some estimates almost the entire adult population is now classified as having at least one chronic disease.

Mental illness is an area of particular concern, he says, where controversy already bubbles around the definitions of attention deficit disorder, autism, and bipolar disorder. The revised diagnostic criteria produced by the American Psychiatric Association (*DSM-V*) could, he warns, unleash a wave of what one psychiatrist calls "false positive epidemics."

And underlying the decisions to broaden disease definitions, he argues, are the conflicts of interest embedded among the decision makers. Of the panel members responsible for the current set of psychiatric definitions in *DSM-IV*, 56% had financial ties to drug companies. The figure for *DSM-V* is unchanged. In other fields the picture is similar. Half the panel members who created the diagnosis of pre-hypertension in 2003 had extensive ties to industry.

As Moynihan says, excuses for the continuation of this state of affairs no longer wash. Those who argue that it's too hard to find experts who don't have industry ties are just not looking hard enough. Major decision making bodies—the Food and Drug Administration and the National Institutes of Health in America, and the UK's National Institute for Health and Clinical Excellence, among others—have adopted zero tolerance on experts with financial conflicts of interest. NIH has gone a step further, excluding those with a declared view on a question being considered. As one NIH senior manager says in the article, "intellectual conflicts of interest can be equally important."

Moynihan proposes going further still, again following the lead from the NIH. Its panels include a broad range of expertise and also, crucially, people representing the wider public interest. Since civil society has a major stake in decisions about where normality ends and disease begins, it should have a say in them as well.

Such panels will of course need good evidence on which to base their decisions, including evidence on the cost effectiveness of changing a diagnostic category. Therein lies the problem. As Moynihan points out, the type of evidence we need is in short supply: "the claims about the nature or extent of medical conditions are rarely exposed to the same rigorous systematic scrutiny as the studies of treatments for them."

I'm struck by the quote from Allen Frances, the psychiatrist who chaired the task force for *DSM-IV*. "New diagnoses are as dangerous as new drugs, he says. "We have remarkably casual procedures for defining the nature of conditions, yet they can lead to tens of millions being treated with drugs they may not need, and that may harm them."

So what should clinicians do, especially in their new extended role as commissioners of care? Be wary of new definitions of disease, question their provenance, make patients aware of the debate, demand greater transparency and tougher rules for decision makers, strive for independence yourself, and seek ways to encourage and reward it in others.

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Career Focus, jobs, and courses appear after p 1090

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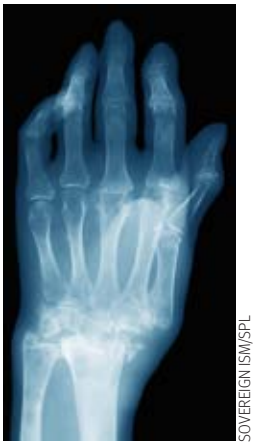

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