tion between mental disorder and ordinary criminality" (*Am J Psych* 2008; 165:1240–1). They concluded that "tinkering with criteria wording should be done only with great care and when the advantages clearly outweigh the risks, both because of the potentially unforeseen consequences of rewording criteria and because of the disruptive nature of all changes."

Because the stakes are high, changes to the *DSM* are not taken lightly. Though there are no restrictions on who is allowed to propose a disorder to be added to the *DSM*, unless a proposal is accompanied by a substantial body of sound scientific data, it stands little chance of success.

"If everybody got their pet condition entered, the *DSM* would no longer be very useful," says Yaren. "It would just be a collection of ideas and theories rather than an attempt to have a validated classification of mental disorders."

The *DSM* revision process is conducted by a designated task force, which establishes working groups to focus on specific diagnostic areas. The process changes with each new edition, but generally adheres to the same pattern: review, consultation, testing.

> "When things get in the *DSM*, it's very hard to get them out. It's like a black hole." — Dr. Michael First, editor of text and criteria for DSM-IV.

An extensive literature review is conducted on the problematic areas of the current edition. Working groups analyze the scientific data and draft initial proposals of possible additions and changes. Other experts are then asked to review these proposals and provide feedback. Then field trials are conducted in mental health facilities and primary care settings to test the feasibility and clinical utility of the proposed revisions. The results shape the working groups final recommendations, which go the American Psychiatric Association for approval.

The biggest change to the *DSM-V* revision process — according to Dr. William Narrow, research director of the *DSM-V* task force — is a new focus on "dimensional assessments," intended to make diagnoses of mental disorders a matter of degree, rather than just a yes or no assessment. "This will hopefully add to the usability of the *DSM* in terms of getting away from the strict categorical direction that the *DSM* has been going in and allow practitioners to actually document in a more quantitative way the comorbidities and the grey areas of their patients' disorders," says Narrow.

A shortcoming of the *DSM* revision process is that the risk of overdiagnosis is usually not taken into consideration by people making proposals for new disorders, says Dr. Michael First, who served as editor of text and criteria for *DSM-IV*. Advocates for adding a particular disorder tend to focus too much on cases they believe are being missed, he says, and too little on the potential of a new entry to create many false positives. The potential good of adding a new disorder to the *DSM* should outweigh the potential harm, says First, because when a disorder gains entry it tends to remain in the manual's pages for a long time.

"When things get in the *DSM*, it's very hard to get them out," says First. "It's like a black hole." — Roger Collier, *CMAJ*

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DSM revision surrounded by controversy

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Former editors of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) have publicly declared their concerns that the ongoing revision process of the influential publication has been cloaked in secrecy. In recent months, debate about the confidentiality agreement that contributors must now sign has been playing out in the pages of the *Psychiatric Times*. Dr. Allen Frances, editor of *DSM-IV*, has written several editorials slamming the *DSM-V* task force for their lack of transparency.

The "real problem now is the almost complete lack of openness about [*DSM-V*] methods, progress, timelines, and products," Frances writes in an email.

Dr. Robert Spitzer, editor of *DSM-III*, has expressed a similar opinion. In 2008, he wrote an open letter criticizing the confidentiality agreement (*Psychiatr News* 2008; 43:26). In the letter, Spitzer says that he requested the minutes of a *DSM-V* meeting but was refused. The confidentiality mandate, he wrote, would prohibit the free exchange of information between the *DSM* task force and outside experts that is essential to effectively revising the manual.

Members of the American Psychiatric Association, which publishes the *DSM*, have countered these criticisms by claiming the revision process has never been more open. There are more than 150 experts from 16 countries contributing to the manual, the association has noted, and the confidentiality agreement serves primarily to protect intellectual property and to allow task force members to provide input on certain matters without fear of outsiders misinterpreting it or coming to premature conclusions.

"With each version of the *DSM* that comes out, there is more and more openness in terms of transparency and in terms of making sure that interested parties are kept updated as well as possible," says Dr. William Narrow, director of the *DSM-V* task force. "But there is a delicate balance between being totally transparent versus allowing a scientific process to take place."

The debate between the former and current editors has taken a turn toward the personal of late. In a response to

criticisms from Frances and Spitzer, members of the *DSM-V* task force accused them of protesting the current process for financial reasons: "Both Dr. Frances and Dr. Spitzer ... continue to receive royalties on *DSM-IV* associated products" (www.psychiatrictimes.com/display/article/10168/1425806?verify=0).

Some critics of the *DSM* process express other concerns in addition to matters of transparency. It's been pointed out that about 70% of current task force members have ties to the pharmaceutical industry, up about 14% for *DSM-IV*. A study of an earlier edition of the manual found that ties to the drug industry are particularly strong in working groups focusing on diagnostic areas in which drugs are the first line of treatment (*Pscyhother Psychosom* 2006;75:154–60). For *DSM-IV*, all of the members of the working groups for mood disorders and "schizophrenia and other psychotic disorders" had ties to drug companies.

"We recommended that they limit the number of people on these working groups with industry ties, making them a minority so they won't dominate," says Sheldon Krimsky, a coauthor of the study and an adjunct professor in the Department of Public Health and Family Medicine at the Tufts School of Medicine in Medford, Massachusetts. "But that hasn't happened yet."

Concerns have been raised that the current revision of the *Diagnostic and Statistical Manual of Mental Disorders* is too secretive.

The study noted that the pharmaceutical industry funds conventions and research related to disorders proposed for entry in the *DSM* because "what is considered diagnosable directly impacts the sale of their drugs."

Members of *DSM* working groups are also wooed by drug companies, Krimsky says, because their involvement with the prestigious manual makes them valuable on the lecture circuit.

"If they start out not having industry connections, they will be tempted by industry to create them," he adds.

But the *DSM-V* task force claims to be addressing these problems with conflicts of interest disclosure. Psychiatrists working on the manual are limited to US$10 000 in consulting fees from drug companies. Defenders of the process also claim that relationships with industry aren't inherently harmful, and that collaboration by government, academia and industry aids development of pharmacological treatments (www.psychiatrictimes.com/display/article/10168/1364672?pageNumber=2).

Another criticism of the current task force is that they are being too ambitious, suggesting that *DSM-V* will be a "paradigm shift" in psychiatric diagnosis. Frances says a conservative approach to revising the manual is more appropriate. A radical change could only be justified if there were a fundamental leap in the understanding of what causes mental disorders, he says, and though advances in neuroscience and brain imaging show promise, that leap has yet to occur. Too many changes to the *DSM* will only lead to many people being mistakenly labelled as mentally ill and put on medications without good reason. In his email, Frances says the "ambition to be innovative, when no substantial innovation is possible, will likely lead to arbitrary changes that will often do more harm than good." — Roger Collier, *CMAJ*

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Care or killing?

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It's been lauded as an evidence-based framework for delivering appropriate end-of-life or palliative care to the terminally ill, and slagged a self-fulfilling proposition that should be known as the "Liverpool Death Pathway," rather than the Liverpool Care Pathway.

A recent care audit given to dying patients in British hospitals, though, has reviewed the medical protocol favourably (www.liv.ac.uk/mcpcil/liverpool-care-pathway/Generic_NCDAH_2nd_Round_Final_PRINTABLE.pdf).

The controversial pathway, which was modelled on care provided at United Kingdom hospices for the terminally ill, was initially developed by the Royal Liverpool Hospital and the Marie Curie Cancer Care, a charity providing home or hospice care to terminally ill patients. Although initially developed for cancer patients, the program was later adapted for other conditions.

The pathway is meant to be applied during a dying patient's last few days and hours. It offers guidance in such areas as symptom control, comfort measures, the discontinuation of inappropriate measures and anticipatory prescribing of medication, along with psychological and spiritual care of the patient and family.

"The Liverpool Care Pathway made physicians aware that the diagnosis of dying has consequences for what they did for patients," says Dr. Bill Noble, president of the Association for Palliative Medicine of Great Britain. "Before this, there was a tendency to simply carry on existing treatments until the patient could no longer endure them."

According to a hospital use template, the pathway should be used when "all possible reversible causes" for a patient's condition have been considered, and a multiprofessional team has agreed not only that the patient is dying but that at least two of the following four criteria are present: the patient is bedbound, only able to take sips of fluids, semi-comatose