

FASD-specific programs will increase wasteful diagnosis-seeking behaviour (as seen in autism spectrum disorder). A universal FASD-specific diagnostic program based on current guidelines is not tenable⁴ and emphasizes the question of qualification for an FASD diagnosis, which is of low practical clinical relevance. The label of FASD carries potential harm to many through stigmatization and prejudice, particularly for those who are in the “at risk of FASD” category.⁵ Ironically, FASD-specific programs will exclude many who are affected by antenatal alcohol but do not meet the criteria.

There is no good quality evidence indicating a need to diagnose children early with FASD (as opposed to diagnosing function-based problems). We need equitable, nonetiologic diagnosis-based services for all people with neurobehavioural disorders. Prioritization for assessment and intervention programs should be based on severity of functional disability, not on etiology. Diagnosticians need to focus on functional impairment rather than often futile (and sometimes damaging) attempts to attribute causality.

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CMAJ 2016. DOI:10.1503/cmaj.1150122

Incentive payments: the correct lesson

Lavergne and colleagues found that incentive payments to primary care physicians for the care of patients with complex disease had no impact on health care outcomes.¹ That’s an

important finding, but the wrong lesson is easily drawn from it.

The correct lesson is not that incentives do not work, but that incentives alone do not work. The key is contained in the first paragraph of their methods section: “British Columbia retained the fee-for-service payment system and made no structural changes to primary care provision, such as the introduction of team-based models of practice.”¹ Our team studied the introduction of incentive payments statewide in Michigan and found substantial reductions in presentation to emergency departments, admission to hospital and cost.² However, that incentive program was implemented with explicit ties to the medical home model. It also included supports such as learning collaboratives to aid practices in transformation.

Incentives are necessary, but they’re not sufficient. This point must be made clear to policy-makers, lest they make the error of discarding incentives rather than connecting them to the structures needed to make them work.

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Assisted dying for patients with psychiatric disorders

The article by Kim and Lemmens contains several important errors and omissions.¹

First, it was Carter, not just the Parliamentary Special Joint Committee on Physician-Assisted Dying, that stated that patients are not required to accept all treatments to be considered “irremediable.”²

Second, the authors failed to reference the judgement from the E.F. case, heard by the Alberta Court of Appeal, which confirmed that Carter neither

requires that death be “reasonably foreseeable” nor excludes people with primary psychiatric illness.³ E.F. was granted access to medical assistance in dying (MAID) by three judges, based exclusively on a psychiatric diagnosis.

Third, Kim and Lemmens reference a study stating that “most” patients with depression achieve remission if given high-quality treatment; however, that “most” was only 60.2%.⁴ We cannot ignore the remaining 39.8%.

Finally, the authors imply that MAID in refractory mental illness would only be acceptable with a zero error rate. Nowhere else in medicine do we require zero risk of error. Unnecessary deaths are tragic; yet so is the counterpart: ceaseless unbearable pain, deplorable quality of life, and loss of self. It is not MAID, but rather denying MAID, that puts “many vulnerable and stigmatized people at risk.” Without MAID, the most irremediable but competent patients would be consigned to years of suffering or a horrific death by suicide.

We must recall the intent of Carter and should trust doctors and patients to make careful decisions, collaboratively, that honour patient autonomy and reduce suffering in the most ethical manner.

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Competing interests: Derryck Smith is a board member of The Committee of the World Federation of Right to Die Societies, and both authors are members of the Physician Advisory Council, Dying With Dignity Canada.

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