even-handed approach in an editorial of a scientific journal is regrettable.

Emile Berger
Neurosurgeon
Montréal, Que.

References
1. The opportunity costs of war in Iraq [editorial]. *CMAJ* 2003;168(9):1101.
2. Lee PS. An open letter from Concerned Medical Students on Iraq [letter]. *CMAJ* 2003;168(9): 1115.

For much of the spring, the media bombarded us with opinions on the war in Iraq. For weeks, it was almost impossible to pick up a newsmagazine or newspaper or to watch television without being verbally assaulted by commentators, editorialists and others of the usual suspects preaching their various points of view.

Today, I picked up *CMAJ* and found the same type of thing on the editorial page.[1]

If *CMAJ*'s editors feel determined to make their own political statement about the merits or lack thereof of the Iraqi war cum police action, they should send their rants to the CBC or the *Toronto Star* or some other suitable media outlet. I would think that there is a sufficient number of difficult and controversial problems in the Canadian medical system to keep the journal's editors busy. We already have more than enough amateur political commentators.

John M. Rapin
Physician
Kingston, Ont.

Reference
1. The opportunity costs of war in Iraq [editorial]. *CMAJ* 2003;168(9):1101.

My first response to the editorial in the April 29 issue[1] was laughter. I have no problem with *CMAJ*'s editors commenting against the war. But the timing was hysterical. When the editorial appeared, the war was essentially over, and the predicted humanitarian crises had been largely prevented. I hate to make a perhaps unfair comparison, but your position was like that of the federal government "bravely" declaring its opposition to the war when it just didn't matter anymore.

As for the position stated in the last sentence, that "the most effective preemptive strikes against global insecurity will take aim at disparities in access to natural resources, economic opportunity, education and health," I couldn't agree more. Now that a brutal tyrant is gone and his oppressive regime is overthrown, Iraqis may finally have the opportunities that have been withheld from them for so long.

Brad B. Bryan
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Reference
1. The opportunity costs of war in Iraq [editorial]. *CMAJ* 2003;168(9):1101.

[The editors respond:]

We do not agree that war is a subject unconnected with medicine. Clearly, the implications of military action — and inaction — for human health are profound. The question of whether the war in Iraq was "just" has given rise to a good deal of agonized debate, and people of conscience have argued strenuously on both sides. In the weeks leading up to the war, risk calulations of various kinds, including the competing "body counts" suggested by Jason Ford, weighed heavily on many people's minds. Our editorial[1] focused on some of the risks posed by unilateral military action, particularly the potential damage to the moral authority of the United Nations and to the capacity of international agencies to continue to work effectively. Some of our readers work with such organizations in Canada and abroad.

With respect to John Rapin's charge that we are amateur commentators, we are pleased to agree. It is a characteristic of healthy democracies that the ethical scrutiny of political and military decisions is not confined to designated experts. That being said, the medical profession can claim expertise with respect to health. It would be remiss, therefore, for medical commentators not to encourage consideration of the health implications of war.

Our concern about the impact of unilateral military action on the structures of international cooperation is a matter of principle that has not been altered by the outcome of the war, even assuming this outcome to be as uncomplicated as Brad Bryan's letter implies. In any event, we would take no satisfaction in seeing any worst-case scenarios come true.

John Hoey
Anne Marie Todkill
CMAJ

Reference
1. The opportunity costs of war in Iraq [editorial]. *CMAJ* 2003;168(9):1101.

What's in a name?

Much could be said about the reasons for the disastrous outcomes of the SARS outbreak, particularly for Toronto and the rest of Canada. Retrospective analyses may come to dissimilar conclusions, depending on the analysts' points of view. I join those who believe that the stigma cast on Toronto was largely a result of the excessive style of the news media — written, spoken and illustrated.[1] It is to my regret (and surprise) that the medical profession, perhaps unwittingly, assisted the media in this dubious achievement. I refer here to the name of the syndrome: severe acute respiratory syndrome. The nomenclature of diseases does not usually include qualifying adjectives. I can think of but one exception, the form of anemia that a century ago was called "pernicious"; now it is known as megaloblastic anemia.

It serves no useful purpose to give a disease a frightening name, and medical science has, until now, wisely refrained from doing so. I hope that the naming of SARS does not herald a new trend toward names such as "terrible acute

leukemia" and "debilitating osteoporosis." In fact, it would be a good idea to rename SARS with a more scientifically acceptable term, free from psychological overtones.

Miklos Nadasdi
General Practitioner
Toronto, Ont.

Reference

1. Schabas R. SARS: prudence, not panic [editorial]. *CMAJ* 2003;168(11):1432-4.

[The News Editor responds:]

Richard Thompson, communications officer for the World Health Organization's Communicable Diseases Section, told William Safire of the *New York Times*[1] that the selection of "severe acute respiratory syndrome" as the disease's official moniker involved lengthy debate. "We wanted a name that would not stigmatize a location, such as 'the Hanoi disease.' We first thought of A.P.W.D., or Atypical Pneumonia Without Diagnosis, and I'm glad we dropped that. Then we simply described the disease in another way, and it was in front of us — Severe Acute Respiratory Syndrome, SARS." Thompson says both qualifying adjectives were needed: "In medicine, severe is 'grave' and acute means 'suddenly.' This respiratory syndrome caused great harm (severe) and had a rapid onset (acute)."

Patrick Sullivan
News Editor
CMAJ

Reference

1. Safire W. Severe/acute. *New York Times Magazine* 2003 May 4. Available: www.nytimes.com (accessed 2003 June 2).

Whose satisfaction?

Brian Hutchison and colleagues[1] described patient satisfaction and quality of care in walk-in clinics and other settings, but their study was biased in favour of lower-acuity illnesses for which there is diagnostic certainty. In this situation, patients' perception of quality of care will be unduly influenced by perceived access to and speed of care. A study using population-based risk and severity categories would have been more informative.

Although the 8 conditions analyzed in the study are common, they are associated with low costs and low overall impact on the health care system, because they tend not to generate consultations, tests or hospital admissions. Patients with chronic conditions and comorbidities make up a smaller proportion of the population, but they account for a large proportion of the costs of care. Furthermore, acute intercurrent illnesses in such patients may result in serious deterioration in health status. Patients from this segment of the population are therefore the most important "customers" in the system.

Continuity of care, in terms of continuity of a relationship with a health care provider and continuity of information management and care planning are also more important in this group. Thus, processes related to continuity of care should come under closer scrutiny, especially in the walk-in clinic setting.

Research into the differences in quality and satisfaction experienced by people with chronic disease and comorbidity who receive care in walk-in clinics, family practices and emergency departments would be of greater overall interest.

Lorne Verhulst
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Strategic Planning Division
Policy Planning and Legislation
Ministry of Health Planning
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Reference

1. Hutchison B, Østbye T, Barnsley J, Stewart M, Mathews M, Campbell MK, et al. Patient satisfaction and quality of care in walk-in clinics, family practices and emergency departments: the Ontario Walk-In Clinic Study. *CMAJ* 2003;168 (8):977-83.

[Three of the authors respond:]

Lorne Verhulst appears to wish that we had conducted a different study. The Ontario Walk-In Clinic Study, of which our study[1] was a part, was designed to examine the role and impact of walk-in clinics in Ontario. Accordingly, in selecting tracer conditions, we chose common acute conditions that are the bread and butter of walk-in clinic business. Although we agree that the patient population Verhulst identifies — those with chronic conditions and comorbidities — are an important target group for primary health care services, they are not a population that we would expect to be served either frequently or well by walk-in clinics. We would welcome and be open to collaborating in future research to identify models of primary health care delivery most suited to the needs of this important patient population.

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Reference

1. Hutchison B, Østbye T, Barnsley J, Stewart M, Mathews M, Campbell MK, et al. Patient satisfaction and quality of care in walk-in clinics, family practices and emergency departments: the Ontario Walk-In Clinic Study. *CMAJ* 2003;168 (8):977-83.

A step backward

As pointed out by Robert Maunder and associates,[1] severe acute respiratory syndrome (SARS) has led to great emotional discomfort for both patients and medical personnel. Even when the outbreak has been brought under control, we will be faced with the ripple effects of the crisis. For example, in my community, consideration is already be-