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
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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.

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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-