

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

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Whose satisfaction?

Brian Hutchison and colleagues¹ 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
Medical Consultant
Strategic Planning Division
Policy Planning and Legislation
Ministry of Health Planning
Vancouver, BC

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 study¹ 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.

Brian Hutchison

Departments of Family Medicine and of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ont.

Truls Østbye

Department of Community and Family Medicine
Duke University
Durham, NC

Jan Barnsley

Department of Health Policy, Management and Evaluation
Faculty of Medicine
University of Toronto
Toronto, Ont.

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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-

ing given to making permanent measures that prevent open visits to hospital patients. After the trend in recent years toward more patient-centred care, we seem to be returning to the older practice of isolating patients from family and friends, an ill-conceived approach that fails to recognize the importance of emotional support in healing.

As a caring medical community, we must avoid accepting the most convenient solution in a crisis situation.

F.P. Gorodzinsky

Associate Professor of Pediatrics
University of Western Ontario
London, Ont.

Reference

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ADHD and driving safety

Margaret Weiss and Candice Murray's article on the management of attention-deficit hyperactivity disorder (ADHD) in adults¹ was exemplary but did not mention one important area of functional impairment: problems with driving.

The greater prevalence of motor vehicle collisions among ADHD patients was first described in follow-up studies of childhood ADHD² and has since been confirmed by other researchers.³⁻⁵ Adults with ADHD who have been characterized as impulsive, fast drivers with attention problems are also prone to aggressive driving and so-called "road rage."

Although CMA recommendations on assessment of fitness to drive⁶ now include uncontrolled ADHD as a medical condition reportable to the provincial ministry of transport, the efficacy of medical interventions in reducing driving risk in adults with ADHD is not well established. In a case series of 100 adults with ADHD whose symptoms were effectively treated with stimulants (either methylphenidate or dextroampheta-

mine), spouses rated the patients as significantly less impulsive and generally safer while driving over a 36-month follow-up period.⁷ Similar supportive studies have demonstrated better driving performance with stimulants than without any medication.⁸

Inquiring about driving history would now seem to be an important part of establishing a profile of functional impairment among adults with ADHD. Further research is needed to establish the efficacy of stimulants and newer non-stimulant medications in reducing collisions in this high-risk population.

Laurence Jerome

Consultant Psychiatrist
Amethyst ADHD Programme
London, Ont.

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2. Hechtman L, Weiss G, Berleman T. Young adult outcome of hyperactive children who received long term stimulant treatment. *J Am Acad Child Psychiatry* 1984;23:261-9.
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[The authors respond:]

We thank Laurence Jerome for pointing out this omission from our article.¹ One of the highlights of recent research on ADHD in adults has been the demonstration that this disorder is associated with increased risk for specific areas of impairment. Some of this impairment

was anticipated clinically, such as the impairment in work and educational achievement predicted by long-term prospective follow-up studies.²⁻⁴ The increased risk for motor vehicle crashes, speeding and traffic violations,⁵⁻⁷ substance abuse⁸ and smoking⁹ clearly indicate that this disorder presents a serious public health concern. We agree that assessment of these specific areas of impairment should be part of both the clinical assessment and the outcome evaluation. In addition, we anticipate that other areas of impairment, such as difficulty with some aspects of parenting and activities of daily living, will be the subject of research evaluation in the future.

Margaret Weiss

Division of Child Psychiatry

Candice Murray

Department of Psychology
University of British Columbia
Vancouver, BC

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