

Women's Health Council, have recognized this gap in scientific evidence and that studies to address this question are under way.

#### Harriet L. MacMillan

Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics

#### C. Nadine Wathen

Offord Centre for Child Studies  
McMaster University  
Hamilton, Ont.

#### References

1. MacMillan HL, Wathen CN. Violence against women: integrating the evidence into clinical practice [editorial]. *CMAJ* 2003;169(6):570-1.
2. Wathen CN, MacMillan HL, with the Canadian Task Force on Preventive Health Care. Prevention of violence against women. Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2003;169(6):582-4.
3. Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. *JAMA* 2003;289:589-600, e1-e10.
4. Chang JC, Decker M, Moracco KE, Martin SL, Petersen R, Frasier PY. What happens when health care providers ask about intimate partner violence? A description of consequences from the perspectives of female survivors. *J Am Med Womens Assoc* 2003;58:76-81.

DOI:10.1053/cmaj.1031877

## The high impact of an influenza pandemic

I applaud the *CMAJ* for its efforts to increase public and political awareness of the potential impact of an influenza pandemic in Canada. However, I would like to clarify one of the numbers that appeared in a recent news article.<sup>1</sup>

It is difficult to precisely quantify — or to exaggerate — the impact of the next influenza pandemic. That impact will depend on how virulent the virus is, how rapidly it spreads from person to person, and how effective and available prevention and control measures prove to be. Estimates based on previous pandemics (in 1918, 1957 and 1968) can be used as a guide, but global travel is far greater than ever before and will no doubt accelerate the speed of international spread, as with SARS.

Models have been developed to estimate the possible impacts of the next pandemic,<sup>2</sup> but they are based on as-

sumptions derived from the US experience, and their applicability to other health care settings or systems is limited. Nor do these models incorporate the use of antivirals or vaccines, should these become sufficiently available.

Estimates of impact can nevertheless be useful in showing the scale or magnitude of the crisis relative to that of other disasters and in increasing the awareness that is critical to preparation and planning required to minimize that impact. Assuming attack rates in the range of 15% to 35% during the next influenza pandemic, the Canadian Pandemic Influenza Plan ([www.hc-sc.gc.ca/pphb-dgspsp/cpip-pclpci/](http://www.hc-sc.gc.ca/pphb-dgspsp/cpip-pclpci/)) incorporates the Meltzer model in estimating that 5–10 million Canadians could become clinically ill, such that they would be unable to attend work or other activities for at least half a day. Furthermore, an estimated 2–5 million Canadians would require outpatient care, between 30 000 and 140 000 would require admission to hospital, and between 10 000 and 60 000 could die. As such, although it is staggering to imagine and difficult to accept, the estimate of 50 000 cited in the *CMAJ* article<sup>1</sup> refers not to the number in Canada who could become ill but to the number who could ultimately perish.

Because communities would be affected over a short period of time (6–8 weeks), simultaneously and possibly in 2 waves during the same season, a pandemic of influenza will be unlike any other catastrophe. The SARS outbreak was an important but limited rehearsal that has helped further refine our preparedness. Technology has improved substantially since avian influenza H5N1 first appeared among humans in 1997, and our ability to detect and respond to this virus and its pandemic potential is far better. Either way, it is clear that a pandemic of influenza has the potential to be exponentially worse than SARS in its capacity to cause human suffering — both illness and despair — let alone economic and social upheaval.

Given the warning signals repeatedly emanating from Southeast Asia, an all-out and unified international effort

to mitigate this possibility should be undertaken now.

#### Danuta Skowronski

Epidemiology Services  
BC Centre for Disease Control Society  
Vancouver, BC

#### References

1. Andresen M. "Imminent" flu pandemic: Are we ready? *CMAJ* 2004;170(2):181.
2. Meltzer M, Shoemaker H, Kownaski M, Crosby R, Smith D. *FluAid 2.0: Estimating the state level impact of pandemic influenza*. Version 2.0 [manual and computer program]. Atlanta: Centers for Disease Control and Prevention; 2000. Available: [www2a.cdc.gov/od/fluaid/](http://www2a.cdc.gov/od/fluaid/) (accessed 2004 Feb 3).

DOI:10.1053/cmaj.1040167

## Direct-to-consumer advertising

Barbara Mintzes and colleagues<sup>1</sup> seem to demonstrate that direct-to-consumer advertising (DTCA) has net benefits, despite their own pessimistic interpretation. Patients who requested advertised drugs received them in 86.5% of cases, whereas only 26.2% of patients who did not make a request received a prescription. However, 74.3% of patients who requested non-advertised drugs received prescriptions. Thus, although DTCA was associated with a greater proportion of requests that were fulfilled, the effect was minor relative to other, unexplained, reasons for requesting prescriptions.

For prescriptions that were given without being requested, physicians considered only 12.1% "possibly" or "unlikely" to be appropriate for similar patients. However, for requested prescriptions for advertised drugs, the share was 50.0%, and for requested prescriptions for nonadvertised drugs it was 39.6%. Thus, the same principle applies here as above.

Of prescriptions for advertised drugs, half were unambiguous (i.e., were not associated with physician ambivalence about appropriateness), and it is not stated how many, if any, of these ambiguous prescriptions had negative outcomes. I have shown elsewhere<sup>2</sup> that if less than 42% of ambiguous prescrip-