Canadian Task Force on Preventive Health Care[3] on preventing influenza in the general population (and the authors of the systematic review were quoted in the lay press as endorsing universal vaccination[4]), when a Cochrane review of the topic[5] already exists.

The Cochrane systematic review,[5] alluded to but not cited by Joanne Langley and Marie Faughnan,[2] concludes that "[i]nfluenza vaccines are effective in reducing serologically confirmed cases of influenza. However, they are not as effective in reducing cases of clinical influenza and number of working days lost. Universal immunisation of healthy adults is not supported by the results of this review."

Langley and Faughnan[2] state that their goal was to determine the efficacy of the vaccine, not the efficacy of a universal vaccination program. Yet it appears that they, and the task force, endorse such a strategy, without evidence related to a variety of ancillary considerations that they identify (including economic costs, vaccine procurement and public acceptability).

Something is missing here. Was the *CMAJ* systematic review not the compelling piece of evidence leading to the task force's endorsement of universal vaccination? Was the conclusion of the Cochrane Collaboration wrong? Is there evidence of cost-effectiveness, and have procurement issues been sorted out? Just how many systematic reviews do we need on a particular topic?

R.A. Fisher, the pioneering methodologist for randomized trials and the most influential statistician of the 20th century,[6] envisioned controlled trials (and, by extension, systematic reviews and meta-analyses) as an essential technique to reduce the interpretive variability of study results. I wish he and Archie Cochrane were still around to help us sort this out.

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[One of the authors and the chair of the CTFPHC respond:]

As systematic reviews and meta-analyses have become established as methods for evidence-based decision-making, reviews on similar questions have been published, sometimes with discordant results. Recommended approaches to reconciling these differences include determining if the results truly differ or if the variation arises from the interpretation of the results.[1] Ross Upshur notes that different conclusions on vaccination of the general public were reached by the Canadian Task Force on Preventive Health Care (CTFPHC)[2,3] and the Cochrane Collaboration.[4] In this case, the reviews covered different populations (healthy adults and children in the CTFPHC review, healthy adults only in the Cochrane review) and considered different interventions (vaccines and neuraminidase inhibitors in the CTFPHC review, vaccines only in the Cochrane review). There were also differences in methods: CTFPHC reviews are systematic qualitative reviews,[5,6] whereas the Cochrane reviews are generally quantitative reviews.[4,7] As noted in the Methods section and Fig. 1 of our review,[2] we reviewed the Cochrane database to find primary trials that might not have been identified in our literature search. The trials that

were judged acceptable were not identical in the 2 reviews.

Perhaps the most important difference between the 2 reviews is in the interpretation of cumulative evidence for influenza vaccination in healthy people. The Cochrane reviewers concluded that the efficacy of inactivated influenza vaccines (the type of vaccine that is available in Canada) was 70% (95% confidence interval 56% to 80%) in healthy adults, but thought that this was insufficient evidence to support general vaccination.[4] The CTFPHC concluded that vaccination was a moderately effective intervention to reduce influenza in adults and children, without evidence of harm, and recommended it.[3] The clinical significance of a 70% reduction in influenza virus infection will likely be of variable importance to patients and their families, clinicians and other health care providers, and payers. The ultimate decision to offer influenza vaccination rests with those who must balance the broader issues of universal programs, such as the practicability of vaccinating large populations in a short period of time, public acceptance, vaccine procurement and the value of this intervention relative to other health prevention or treatment interventions.

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Earning our patients' trust

A recent editorial in the *CMAJ*[1] used notorious British family physician and serial murderer Harold Shipman as an example of how "professional malfeasance" wrought by physicians has eroded public confidence in physicians. While I could not agree more that public confidence and trust in physicians are the cornerstones of the physician–patient relationship, I challenge your assertion that "confidence in physicians is waning."

Physicians in Canada continue to be described as very trustworthy[2] in surveys designed to measure how much various professionals are trusted by the public. Being identified as one of the most trustworthy professions, along with nurses and pharmacists, is not an honour either bestowed or received lightly.

Canadian advocacy and regulatory bodies have reaffirmed the need for maintaining the highest possible ethical standards, physician competence and lifelong learning. Perhaps most importantly, a new era of openness and transparency has begun, with increased public representation on the governing councils of the colleges of physicians and surgeons and regular, publicly accessible reports on disciplinary actions and investigations.

The Shipman case represents a tragic episode in the history of medicine, and as physicians we all recoil at the horror and pain this individual