spective baseline risks, the interpretation of ratio effect measures may be misleading. It has previously been demonstrated that careful epidemiologic studies that mimic the exclusion criteria of RCTs are likely to result in the same effect sizes as the RCTs.[5] The strength of many nonrandomized studies is their assessment of harms of medical interventions in populations that are usually excluded from RCTs.

Sebastian Schneeweiss
Daniel H. Solomon
Division of Pharmacoepidemiology and Pharmacoeconomics
Department of Medicine
Brigham and Women's Hospital
Harvard Medical School
Boston, Mass.

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[Two of the authors respond:]

We thank Schneeweiss and Solomon for their interesting comment. We fully agree that nonrandomized studies often include high-risk populations that are excluded from randomized trials. However, this is not an absolute rule. While some of the discrepancies between absolute and relative effect metrics may be explained by differences in baseline risk, this has to be checked on a case-by-case basis. It is also very difficult to reach consensus whether harmful effects are described more appropriately in the absolute or multiplicative scale, so we opted to show both in our evaluation.[1] Besides genuine differences in absolute risk, measurement problems and bias should also be considered. Absolute event rates may vary considerably across studies, regardless of design, because of many reasons. These include differences in the definition of the adverse event; the captured range of severity; the threshold of patients and physicians to report (often a reflection to the extent to which they are sensitized); the mode of data collection (in particular, active versus passive surveillance for harms); and whether any efforts at attribution have been made.[2,3] In the absence of standardization of collection and reporting of information,[4] comparisons of absolute event rates may sometimes remain tenuous. Therefore, while absolute event rates are clinically most meaningful and can be readily translated to numbers needed to harm, relative risks may be somehow more robust.

John P.A. Ioannidis
Panagiotis Papanikolaou
Department of Hygiene and Epidemiology
University of Ioannina School of Medicine
Ioannina, Greece

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Virtual links to the emergency department

Eddy Lang and colleagues were quite optimistic in their expectations of the power of communication between the emergency department (ED) and family physicians.[1] We all want to reduce duplication and unnecessary admissions to hospital. These benefits of an electronic communications system, however, would not attract me as a practising family doctor. Instead, the benefits I find useful are the time saved in not having to hound hospitals for information and the increased comfort I would feel in knowing what had actually happened to my patient in the ED. Family physicians are leaving their practice in droves and having timely information to make clinical decisions is one factor that may make family practice more palatable.

Laura K. Muldoon
Family Physician
Ottawa, Ont.

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We wish to congratulate the authors for this well done study on an important research question: they found that an electronic link between an ED and family physicians produced no effect.[1]

In eHealth, failure to use technology is frequently observed, and is an important outcome.[2] The authors of this study should report access and usage by the family physicians; if the communication software was infrequently used, it would not have changed outcomes.

Our second area of concern is the choice of family physicians eligible to participate. The authors chose physicians with the highest number of patient visits to emergency; the 43 eligible physicians likely represent about 10% of all family physicians at their institution. Comparing their characteristics with those of their peers may be worthwhile. The average practice size for physicians in the study is 4184 patients.[1] In Ontario, the Family Health Network contract limits groups to an average practice size of 2400 patients for full payment. Partic-