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.

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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.

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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.

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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-

ipants also had older patients (33% age 70 and older), with significant numbers of patients having chronic illnesses (49%) and being co-managed by specialists (39%). It is possible that the volume and difficulty of their daily practice precluded change even with better communication. We wonder if the results would have been different with a more representative physician population and if these results are applicable outside of settings with limited computer usage and high practice volumes.

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[Three of the authors respond:]

We welcome the comments of Dr. Muldoon and could not agree more with her perspective. As an ED-led research initiative, the primary study outcome that was emphasized related to factors that impacted the most on ED functioning and resource utilization.[1] Although these results were disappointing, we also measured the impact of the electronic link on measures of continuity of care such as family physician confidence and management plans as enhanced by the information received and general measures of physician satisfaction. These results are very favourable.

We also are thankful for Dr. Greiver and Dr. Eysenbach's astute observations. We have extensive data on the utilization of the electronic communication tool by the 23 family physicians recruited in the study. Our information is derived from electronic log-in records and informs us about the number of times that each patient report was accessed by the intended family physician recipient. Overall, physicians accessed these reports 2.1 times per patient visit. Subsequent log-ins were frequently needed as email updates would be sent out if a pending result became available (e.g., a bacterial culture). In our view, this represents a moderate to high level of utilization of the application. We agree that the sheer volume of patients that community family physicians in our busy urban setting have to manage may preclude an effective change in practice resulting from electronic linkage information. Unfortunately, reduced access to primary care physicians has created a new normal in practice size for many physicians, and it is our view that if this intervention's impact on resource use cannot be appreciated when family physicians are receiving several reports a month on their most needy patients we are doubtful that an impact would be measurable if the reports were issued only a few times a year.

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Correction

In the obituary notice for Dr. Hubert John Warrick,[1] his place of graduation was mistakenly listed as University of London. He graduated from the medical school at St. Mary's Hospital in London, England.

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1. Deaths. *CMAJ* 2006 175(1):119.

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