

Response to Dr. Majumdar

In response to “No more dithering on e-health: let’s keep patients safe instead,”¹ Dr. Majumdar argues that the jury is still out on electronic health records (EHRs).² Based on what evidence? On safety, he is concerned with implementation problems and patient harm. For implementation, our successful peer nations can provide options for phasing in universal electronic systems smoothly and effectively. Regarding patient safety, his evidence is a pre-post study covering five months in one US hospital over seven years ago. There are tens of thousands of preventable adverse events every year in Canada; an integrated and universal data infrastructure could help reduce them and facilitate coordinated care for patients with complex conditions. We have no illusions that EHRs will fix all the problems in health care. However, we’re already spending billions, the potential benefits are large and the experience of other nations suggests EHRs are a nec-

essary step toward improved quality and safety.

Kimberlyn McGrail PhD

Michael Law PhD

Centre for Health Services and Policy Research, University of British Columbia, Vancouver, BC

REFERENCES

1. McGrail K, Law M, Hébert PC. No more dithering on e-health: let’s keep patients safe instead. *CMAJ* 2010;182:535.
2. Majumdar SR. Waiting for evidence? [letter]. *CMAJ* 2010;182:700.

For the full letter, go to: www.cmaj.ca/cgi/ele-ters/182/6/535#330777

DOI:10.1503/cmaj.110-2065

Correction: Research

The article “A network meta-analysis of randomized controlled trials of biologics for rheumatoid arthritis: a Cochrane overview”¹ published Nov. 24, 2009, contained incorrect information, including several numbers needed to treat and 95% confidence intervals in

Table 2 and some numbers in Table 3. As well, in Figure 2, the dotted line should go through 1.0, not to the right of it, and in Figure 3, Etanercept, *I* should be 0% not 94%. In the Methods section, the following sentence should have been added: “Studies using the recommended, approved doses of biologics were included in this network analysis.” In the subsection “Number needed to treat,” the third sentence should read: “The numbers needed to treat for benefit were 3 (95% CI 3–5) for etanercept, 4 (95% CI 3–6) for adalimumab, 4 for (95% CI 3–8) for rituximab, 5 (95% CI 3–10) for abatacept and 5 (95% CI 3–18) for infliximab.”

A corrected PDF is available online at www.cmaj.ca/cgi/data/cmaj.091391/DC2/1.

REFERENCE

1. Singh JA, Christensen R, Wells GA, et al. A network meta-analysis of randomized controlled trials of biologics for rheumatoid arthritis: a Cochrane overview. *CMAJ* 2009;181:787-96.

DOI:10.1503/cmaj.110-2068



PAIN MEDICATION CAN TREAT THE SYMPTOMS. IT'S TIME TO TREAT THE CAUSE.

No one wants to see their patients dependent on pain medication to manage their chronic back and neck pain. True non-surgical decompression therapy is a non-invasive option that may remove or reduce pain so significantly that it decreases or eliminates the need to prescribe pain medications.

GET YOUR FREE DOCTOR KIT TODAY AT
www.spinaldecompressionkit.com
 Our free Information Kit will help you better determine which patients are good candidates for true non-surgical spinal decompression.



LOW BACK CLINIC
 Specialized Care For Severe Neck & Back Pain