pragmatic randomized clinical trials. Its measurements can also inform the decision-making of patients, clinicians, and stakeholders. An additional important metric that could be reported for clinical trials is the FI minus the number of patients lost to follow-up, as it can often be argued that number of patients lost to follow-up could have altered the statistical results of the trial.³

Chaitoff et al remark that highly fragile trials are markers of “good power calculations and trial design.” This is not always true. While ethics dictate designing trial sample sizes to produce the required level of evidence using the minimum number of patients, fragile trial results contradicted by subsequent studies or requiring confirmation from other trials can be harmful to patients and present an equally important ethical conundrum.

The basis of a good trial design, ultimately, is the delicate balance between the number of patients whose treatment is based on randomization and the solidity of the results. The FI is an important first step in this direction.

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CORRECTION

Error in Key Points and Omission of Collaborators in Article Information: The original investigation titled, “Factors Associated With Death in Critically Ill Patients With Coronavirus Disease 2019 in the US,” published online July 15, 2020, contained errors in the Key Points and the Article Information. The revised sentence in the Key Points reads, “Factors associated with death included older age, male sex, morbid obesity, coronary artery disease, cancer, acute organ dysfunction, and admission to a hospital with fewer intensive care unit beds.” In the Article Information, a listing of the STOP-COVID investigators was added. This article has been corrected online.


Error in Figure 2: In the article titled “Effects of Time-Restricted Eating on Weight Loss and Other Metabolic Parameters in Women and Men With Overweight and Obesity: The TREAT Randomized Clinical Trial,”¹ published online on September 28, 2020, in JAMA Internal Medicine, there was an error in Figure 2. The data were not correctly aligned in panel C on the right. The y-axes were also mislabeled in both parts of panel C. This article was corrected online.


Errors in Wording and a Percentage: In the Special Communication “Drug Reimbursement Regulation in 6 Peer Countries,” published online in JAMA Internal Medicine on September 28, 2020,¹ there were errors in 2 statements. In first sentence of the fourth paragraph, the phrase “as part of marketing approval” has been removed from the sentence, which now reads: “In Australia, pharmaceutical companies submit clinical and economic evaluations and cost-effectiveness analyses (CEAs) to the Pharmaceutical Benefits Advisory Committee (PBAC), an independent body appointed by the government composed of health care professionals, economists, and consumer representatives.” In the sixth paragraph, the third sentence has been corrected to indicate the correct percentage of price reduction when a second bioequivalent or biosimilar drug enters the market in Australia; it is a 25% reduction, not 16% reduction. In addition, the following sentence was added for clarification: “Manufacturers must disclose ex-factory prices for formulary 2 drugs to the Department of Health, which may decrease the PBS price to meet the ex-factory price.” The article has been corrected online and the corresponding author has offered an explanation in online Comment on the article.¹