the "recipe" for the enemas, which are easily manufactured by hospital pharmacies.

My final comment is about the target audience for this book. When I was invited to write the book, the goal was to create a user-friendly, comprehensive text for patients and their families. Reviews to date indicate that this objective was achieved. However, colleagues have pointed out to me that the book is also very useful for medical students, house staff, family practitioners, general internists and other health care professionals.

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Modifying prescribing of regulated analgesics

In response to our previous article "Effectiveness of notification and group education in modifying prescribing of regulated analgesics" (*Can Med Assoc J* 1996;154:31-9), by John F. Anderson, Kimberley L. McEwan and William P. Hrudey, it has been suggested that longer follow-up may reveal important differences between the education and the notification intervention with respect to reducing prescribing of regulated analgesics.[1] To this end, we have examined prescribing data for the 7 to 12 months after the intervention by conducting a 1-way analysis of variance (ANOVA) of the difference scores in prescribing between baseline and 1-year follow-up. The original article had examined prescribing patterns after only 6 months in 3 groups of physicians: those who underwent group education, those who were notified of their prescribing status, and those subject to no intervention (the control group). At that time, prescribing of analgesics was significantly reduced in both intervention groups compared with the control group, but no statistically significant difference was found between the education group and the notification group.

Results of the ANOVA based on 1-year follow-up data revealed no overall difference among the groups, suggesting that reductions in prescribing seen after 6 months diminished over time. Although at 1-year follow-up the prescribing practices of the physicians exposed to the interventions were no longer significantly different from those of the control group, there was a trend similar to that found in the first study. The mean difference scores were aligned with the intensity of the intervention, with education showing the greatest reduction and no intervention (the control group) showing the least. We also noted that 76% of the education group, 65% of the notification group and 53% of control group continued to prescribe narcotic analgesics at a rate lower than their rate at baseline. In a larger sample, these differences may have emerged as significant.

We attempted to determine whether group education was superior to notification in reducing prescribing of regulated analgesics over a 1-year period in a sample of 49 physicians and found no support for this hypothesis. We acknowledge, however, that our limited sample size may not have been adequate to test Britten's[1] hypothesis. The durability of interventions to alter prescribing warrants further investigation.

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When physicians' loved ones are patients

Dr. Michael C. Klein's thoughtful and courageously written article, "Too close for comfort? A family physician questions whether medical professionals should be excluded from their loved ones' care" (*Can Med Assoc J* 1997;156:53-5), struck a nerve. It has been 3½ years since my wife Kathy had a myocardial infarction, and we too had both good and bad experiences with the medical and nursing professions. I still cannot think about those experiences without feeling a great deal of anger toward those who treated us poorly and gratitude that we finally found a team that gave us high-quality care. Even now, it is hard for me to write about it.

I will not go into the details of our experience, but I will make some general observations. I am a pediatrician and my wife is a nurse who used to work in intensive care. When she became ill, the staff at the first hospital resented what they described as my "omnipresence." They could not

see that Kathy was frightened and could not relax without a friendly face around. As a pediatrician, I accept the presence of family by the bedside as routine, but somehow in adult medicine this is considered bizarre. That I was seen as a threat was obvious; only a few physicians spoke to us like human beings.

When Kathy was discharged, our family physician was a source of comfort as well as care. However, the specialist who cared for her showed his discomfort by resorting to humour. I felt that he was not listening to my concern that Kathy was experiencing unstable angina. It turned out that she was and that she required a quintuple bypass graft.

That operation was performed at St. Paul's Hospital in Vancouver, and I cannot say enough about the staff there. The physicians and nurses at St. Paul's enlisted me as an ally. The nurses called Kathy their nursing sister and gave her excellent care. It was a refreshing change.

I too had problems with colleagues who felt that I was harassing them about various aspects of her care. Some could handle the acute care but had difficulty dealing with the residual effects of the disease, particularly the emotional aspects.

I think that most physicians who have seen their spouse become critically ill have had similar experiences. I believe that Kathy has become a better nurse and that I have become a better physician as a result. I do not have an answer to Klein's question about how to be vigilant but not overbearing. At times relatives of the sick must be both, especially when dealing with professionals who will not listen.

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I am grateful to Dr. Klein for raising the issue of family involvement in medical care. I suspect it rings bells with most physicians. I also have some experience with this subject and have a suggestion.

Why not keep the patient's chart in his or her room and let the patient decide who may look at it? Nothing would prevent daily charting duties from being performed in the nursing station and those sheets being added at the end of each day. I suspect that the legibility of records would improve. Even a nonmedical family member could then detect the contradiction between a "no added salt" dietary order and an order for extra Oxo cubes at each meal. I think such a measure would help solve many communication difficulties between family members and hospital staff. It would certainly make the experience of hospital care less opaque.

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Canada's largest magnet finds home in new MRI program in London [correction]

Because of incorrect information supplied to the author, this article by Michael OReilly (*Can Med Assoc J* 1997;156:69-70) contained some errors. Dr. Seiji Ogawa, whose surname was misspelled, developed the principles behind functional MRI (fMRI) at AT&T Bell Laboratories, and then worked with Dr. Kamil Ugurbil's MRI research group at the University of Minnesota to produce one of the seminal papers demonstrating fMRI in humans. Although Dr. Ravi Menon was involved in the project as a postdoctoral fellow, he did not codevelop the technique. As well, the system was built by Siemens Medical Systems, but in conjunction with Varian NMR Instruments. We apologize for these errors. — Ed.

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