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.

Jonathan D. Slater, MD
Kamloops, BC
Received via e-mail

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.

Anthony R. Wells, MD
Toronto, Ont.

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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