high-fidelity aviation (and operating room[2]) simulators is not just mastery of "stick and rudder" skills, but also the learning and practice of traits vitally important in team interaction: communication, decision-making and conflict resolution. Unfortunately, virtual reality as described in the sidebar is a single-participant trainer, allowing only one individual to experience 3-dimensional re-creations of, for example, a virtual patient. Team members cannot experience the training simultaneously (although, in the case of aviation, one individual can interact with the flight management computer, which becomes an "electronic crew-member"[3]). For this reason, the need for high-fidelity simulation — which allows entire teams to participate[4] — will continue to be both important and necessary.

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References

1. Helmreich RL, Davies JM. Anaesthetic simulation and lessons to be learned from aviation. *Can J Anaesth* 1997;44(9):907-12.
2. Burt DER. Virtual reality in anaesthesia. *Br J Anaesth* 1995;75:472-80.
3. Helmreich RL. Flight crew behaviour. *Soc Behav* 1987;2:63-72.
4. Helmreich RL, Davies JM. Human factors in the operating room: interpersonal determinants of safety, efficiency and morale. In: Aitkenhead AR, editor. Quality assurance and risk management. *Baillieres Clin Anaesthesiol* 1996;10:277-95.

Of fads and editorials

I find it regrettable that Drs. John Hoey and Kenneth M. Flegel, in their editorial "The times they are confusing: What lies ahead for the new health minister and physicians in Canada?" (*Can Med Assoc J* 1997; 157[1]:39-41) use the term "fad" to describe the proposal to make prescription drug coverage universal.

This proposal has been given careful consideration by politicians in at least 2 of the major parties, as well as by the National Forum on Health.

The lack of universal drug coverage in Canada is incongruous: legislation assures free universal coverage of physicians' services but fails to guarantee the same for treatment prescribed. Prescription drugs are included in the universal health coverage of other industrialized countries — which, incidentally, have lower overall costs for health care as a percentage of GDP.

The writers might let us know what else they and the CMA (if they are speaking for that organization)

consider "fads." Votes for women and ending child labour, perhaps?

Bob Frankford, MB, BS
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Received via email

[The authors respond:]

Two colleagues have disagreed with the position we took against pharmacare in our July 1 editorial.

We agree with Dr. Joel Lexchin's implication that a cost is a cost is a cost ("Can a health care system change?" [letter], *Can Med Assoc J* 1997;157[5]:507-8). From the broad viewpoint of society it makes little difference who pays for a prescription drug (or, for that matter, a nonprescription one). However, in the politics of the turn of the century, it makes a huge difference. It seems clear to us that Canadians do not want to pay higher taxes. Thus, it is unlikely that Canadian politicians will toss new money toward drugs, and they will be reluctant to accept theoretical arguments of potential cost savings. Pharmacare is a big-ticket item and a big risk. Its promoters need to address this basic political reality.

To Dr. Frankford we are tempted to respond "fiddle-*fad*dle." Canadians benefit from an excellent medicare system that is universal to the extent that everyone is covered for the same services. But it is not comprehensive and was never intended to be. Lots of medical services are not covered by the public system, and we know of no other country with a publicly financed system of comprehensive health care coverage. Can our system be improved? Sure it can, but we are predicting that pharmacare will not be among the improvements.

One final point. The editorial section in *CMAJ* is a forum for the free expression of a clearly argued point of view on a matter of professional interest. The positions taken by the authors of editorials are not necessarily those of the CMA. Signed editorials are the responsibility of the author or authors, even when those authors are also editors of the journal.

John Hoey, MD
Editor-in-Chief
Kenneth M. Flegel, MD, MSc
Associate Editor
CMAJ

Guidelines for the diagnosis and management of migraine in clinical practice [correction]

This article, by Dr. William E.M. Pryse-Phillips and associates (*Can Med Assoc J* 1997;156[9]:1273-87), contained an error in the time for symptom relief by sumatriptan. This orally administered drug has been shown to relieve up to 70% of migraine attacks at 2 hours, not 1 hour, as was stated in the article. — Ed.

Pheochromocytoma manifesting with shock presents a clinical paradox: a case report [correction]

In this article, by Jason Ford and associates (*Can Med Assoc J* 1997; 157[7]:923-5), the academic credit of the first author was listed as "BSc." In fact, at the time the article was submitted, Dr. Ford had not completed any academic degree, although he has since graduated from medical school. — Ed.

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