fees or regulations and no more disputes over transfer payments.

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Reference

1. Lewis S. The bog, the fog, the future: 5 strategies for renewing federalism in health care [commentary]. *CMAJ* 2002;166(11):1421-2.

[The author responds:]

I am delighted C.N. Ghent has pointed out in response to my article[1] the folly of fragmentation that consumes so much energy for so little gain. About a year ago, I drafted an op-ed piece entitled "time to punt." I sent it to a number of newspapers urging the provinces to give up constitutional responsibility for health care and allow Ottawa to create a unitary system. All declined to publish it; perhaps they thought I was kidding and their satire quota had been filled for that month.

If we were just now assigning federal and provincial constitutional powers, would we toss health care into Section 92 (as did the Fathers of Confederation when negotiating the British North America Act) knowing what we know about how big and complicated the sector would grow? I'd suggest no. If we did not have to amend the Constitution to transfer the powers back, perhaps it would be an idea worth pursuing. Unfortunately, there is no chance of amending the Constitution to give Ottawa more power rather than less, even if this would be prudent from the standpoint of the provinces. But if Ghent would like to establish an advocacy group for a truly national and nationally governed health system, I could probably be signed up as a charter member.

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1. Lewis S. The bog, the fog, the future: 5 strategies for renewing federalism in health care [editorial]. *CMAJ* 2002;166(11):1421-2.

Low-dose droperidol

Eric Wooltorton's recent drug alert[1] on droperidol adds little to the scant information initially released by the US Food and Drug Administration (FDA). Droperidol has a long history of safe use, is inexpensive and effectively treats postoperative nausea and vomiting. Millions of patients have received droperidol, suggesting that the rate of cardiac complications is extremely low. The new recommendations for giving droperidol (preoperative electrocardiogram, 2–3 hours of postoperative cardiac monitoring) will effectively kill its use.

Studies of droperidol's effect on cardiac conduction have used doses (0.25 mg/kg) far above those used to control postoperative nausea and vomiting (0.625 mg).[2] The FDA has admitted that it has little data on low-dose droperidol, yet it has published the "black box" warning. The FDA has since announced that it is conducting a "definitive pharmacokinetic/pharmacodynamic study" on low-dose droperidol, as well as a comparison between droperidol and other antiemetics and their respective adverse effects.

Health Canada released a drug safety letter on Feb. 12[3] but did not address it to anesthesiologists. It repeated the December FDA warning without details of the QT prolongation cases that prompted the letter. Perhaps after the cisapride fiasco, Health Canada wished to forestall further criticism rather than actually enlighten physicians. This is not in the public's best interest, especially if they are nauseated postoperative patients.

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2. McCormick CG. FDA Alert: Current FDA report on droperidol status and basis for "Black Box" warning. *ASA Newsletter* 2002;66(4):19-20.
3. Health Canada. *Cardiovascular toxicity with injectable droperidol*. Ottawa: Health Canada; 2002 Feb 12. Available: www.hc-sc.gc.ca/hbp- dgps /therapeut/zfiles/english/advisory/tpd/droperidol _e.html (accessed 2002 July 8).

[The author responds:]

Greg Allen highlights certain problems inherent in Canadian "Dear Health Care Professional" letters: one-time maldistribution of information that is missing clinically important content. The original letter[1] signed by Health Canada was addressed to "Hospital Chief of Medical Staff, Otolaryngologists and Pharmacists in Retail Pharmacies." It was overlooked by many who might actually be prescribing the drug, including anesthesiologists, emergency physicians and psychiatrists.[2]

In *CMAJ*'s Health and Drug Alerts, we sought to broaden the awareness of the problem with droperidol and to provide additional clinically relevant information, such as a list of medications that cause QT prolongation. The quality of Health Canada's advisories has been criticized in the past as contributing to preventable medication adverse events,[3,4] and clearly reform is still needed.

Eric Wooltorton
CMAJ

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2. Wooltorton E. Droperidol: cardiovascular toxicity and deaths. *CMAJ* 2002;166(7):932.
3. Lessons from cisapride [editorial]. *CMAJ* 2001; 164(9):1269.
4. Sibbald B. Cisapride, before and after: still waiting for ADE-reporting reform. *CMAJ* 2001;165 (10):1370.

Latent tuberculosis treatment

Kevin Schwartzman's excellent commentary[1] has highlighted an inconsistency in current Canadian guidelines:[2] he recommends treatment of latent tuberculosis (TB) infection for HIV-infected immigrants from TB-endemic countries, even if that person has a tuberculin skin test (TST) reaction of < 5 mm. This group would be composed of the truly uninfected, who would derive no benefit from this treat-