Any licensed physician in Canada is eligible for Canadian Medical Protective Association membership. The association has no control over licensing. "We do share your concerns that this is an area that needs watching," said Dr. John Gray, executive director and chief executive officer. Gray added that the association "commits to work with the regulatory colleges ... to try and make sure issues of patient safety are raised at the community level, institutional level and that civil claims are addressed."

Gray also warned members to beware of risks from current national measures to tackle wait times. "Accountability and liability concerns may put physicians at risk," said Gray. "We do have concerns that may be lost in the debate about numbers and funding. There's a current lack of clarity."

Gray said it's not clear under wait time strategies who is responsible for what, and whether there's a potential liability for doctors if they're found accountable. "We risk the situation of 'having everyone accountable means that no one is'."

The danger is that if a patient suffers an adverse effect from a long wait time, the courts may assume that evolving guidelines represent standards and may hold doctors accountable to them.

"Physician groups and others should be cautious," said Gray, warning of "unintended legal consequences."

"Courts, regulatory colleges and patients will continue to hold doctors accountable to how they treat individuals, regardless of the pressures to treat waiting lists," he said.

The lack of reliable data also emerged as a wait time problem. Different jurisdictions are using different methods to collect data about wait times, said speaker Dr. Lorne Bellan, a Winnipeg ophthalmologist and co-chair of the Wait Time Alliance. Another problem, said Bellan, is that when wait times are calculated, they don't take into account the time between when a general practitioner refers a patient to a specialist, and when that first visit takes place. "Unless we measure that whole wait, we're really not getting a true picture," he added.

The lack of data may increase the risk of liability for primary care physicians, he suggested, because they have no way of knowing how long it will take for their patients to see a specialist after a referral. "You can't fix problems like this unless you can measure them." — Deborah Jones, Vancouver

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News @ a glance

Adverse events documented: An analysis of adverse event surveys and patient safety indicators by the Canadian Institute for Health Information reveals that Canada still lags behind other nations in reducing risk. The analysis states that in 2005, 1 in 10 adults with health problems reported receiving the wrong medication or wrong dose in the previous year. In 2006, 10% of Canadian primary care doctors said they routinely received drug alerts via email, significantly fewer than in the United States (23%), Germany (40%) or Australia, New Zealand, the Netherlands and the United Kingdom (80% or more).

Physicians take the challenge: More than 100 physicians and health care professionals donated all or part of a day's income to support primary health and development in rural Africa. The Canadian Physicians for Aid and Relief's World Health Day Challenge on Apr. 7 raised more than $60 000 — double what was raised during the inaugural challenge in 2006. Founded in 1984, Canadian Physicians for Aid and Relief works in partnership with vulnerable communities and diverse organizations to overcome poverty and build healthy communities in Ethiopia, Tanzania, Uganda and Malawi.

US Medicare won't pay for adverse events: The US federal government has decided that Medicare will no longer bear the financial burden of treatments caused by preventable errors, injuries and infections in hospitals. Among the conditions "that could reasonably have been prevented" are pressure ulcers, injuries caused by falls and infections resulting from the prolonged use of catheters. The plan will save Medicare about US$20 million annually; the hospitals cannot bill patients who suffer from these hospital-acquired complications.

Expand use of mosquito nets: New World Health Organization (WHO) guidelines recommend that long-lasting insecticide-treated nets be distributed either free or heavily sub-

Courtesy of CPAR

Orphans and vulnerable children at the Community-Based Childcare Centre, built by Canadian Physicians for Aid and Relief, in Chintheche, Malawi.

sidized and used by all members of the community in nations in which there is a high risk of contracting malaria. Previously, WHO recommended the nets for children under 5 and pregnant women. A 2-year study in Kenya shows that expanding the use of nets to all people in targeted areas can help reduce overall incidence of malaria. The nets cost about US$5 each.

WOW Web site: A portal for health consumers and practitioners has been created to disseminate information about 3 major health concerns of older women: urinary incontinence, memory loss and exercise. Launched in response to the findings of a study on older women's health needs and concerns (*CMAJ* 2005;173:153-9), the Web site, wowhealth.ca, provides information about prevention, lifestyle, nutrition and treatment options related to the 3 concerns. A separate portal for physicians outlines "the kinds of question that practitioners should be asking their older female patients routinely, and the ways in which they can provide prevention and improvement strategies to their patients." — Compiled by Barbara Sibbald, *CMAJ*

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Pulse

Differences in the proportion of boys and girls enrolled in primary school

Recent data from the World Health Organization show that the proportion of boys and girls enrolled in primary school differs by country (Figure 1). Of the 153 countries for which data were reported, 30 had at least 5% more boys than girls enrolled. In contrast, only 5 countries reported such a difference in favour of girls. There was no difference in the proportion of girls and boys enrolled in primary school in Japan, Italy, France and the United Kingdom. Canada reported a 1% difference in favour of girls, and the United States reported a 4% difference in favour of boys.

Countries with the greatest imbalance in favour of boys were Yemen, Chad, Benin and Pakistan (20%–24%). No countries had such a great imbalance in favour of girls; however, Lesotho, Malawi, Namibia, Suriname, and Saint Kitts and Nevis each had at least a 5% difference.

These data show large inequalities for a primary school education for girls in a number of countries. The data also show that in several countries fewer boys than girls were enrolled in primary school; however, the differences are not as great as for girls and in general it is a rare phenomenon. — Mark O. Baerlocher MD, Toronto, Ont.

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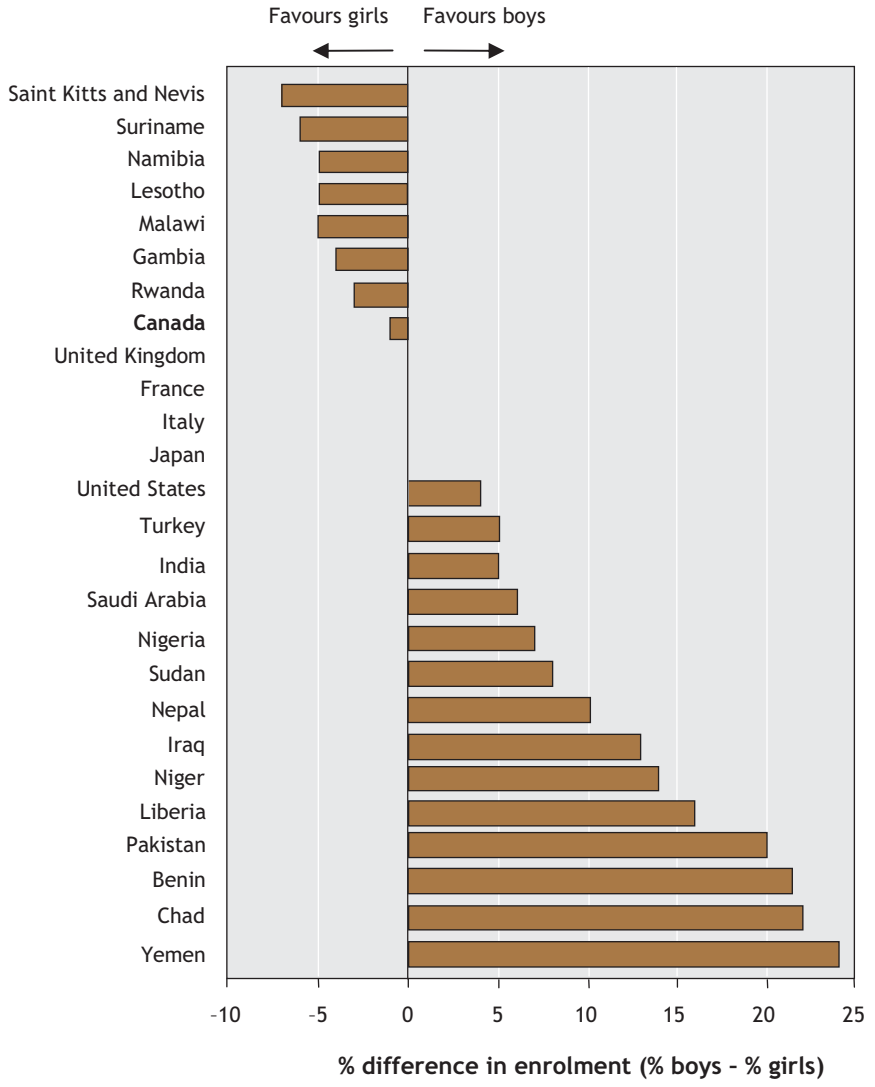

Figure 1: Proportion of boys and girls enrolled in primary school by country. Source: Core health indicators, World Health Organization, 2007 (available: www.who.int/whosis/database/core/core_select.cfm).