


mechanisms now, the entire reform effort will likely be defeated. Now is the opportunity to start “treating” the United States healthcare system; let’s not allow the opportunity this fiscal crisis presents to go to waste.

In addition to strengthening the ailing American healthcare system, the Obama plan has important implications for other developed countries. Many developed countries are dealing with similar issues of escalating healthcare costs while trying to provide equitable access to high-quality care, and Canada is certainly not an exception. As healthcare is becoming the most expensive social program, Canadians are grappling with the issue of public versus private insurance financing. The geographical proximity of the United States and Canada, along with their highly integrated economies means that United States’ healthcare reform will undoubtedly have significant future implications for Canada. 

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Teaching Socially Responsible Medicine in the Himalayas: A Lofty Pursuit

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Nine years ago at a hospital in Kathmandu, Nepal while on Intensive Care Unit rounds with Dr. Arjun Karki (a Nepali-trained doctor), we stopped at the bed of a twelve-year-old girl whose foot had been amputated that morning as a result of a car accident. I asked Arjun “What will become of her?” Perhaps she would have to get a prosthesis, or have to use a cane? Dr. Karki looked at me with troubled eyes and said, “Her chances are actually quite limited.” Dr. Karki explained that the infection could get worse (indeed she lost half her leg later that day). Furthermore, because she was from a poor, rural district with no medical facility, her parents would be unlikely to afford the necessary medical care that Dr. Karki initiated in the city.

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Dr. Karki’s statement pointed to the reality of how in some parts of rural, mountainous Nepal, the ratio of patients to doctors is 150 000 to 1. How is that possible in a country where more than 1000 new doctors graduate each year from 12 medical schools? A problem with retaining physicians in the country is one explanation, as 80% of the graduates will write licensing exams for practice in other countries. For those who stay in Nepal, they opt to practice close to, or in, the city of Kathmandu.

Last year the Kathmandu Post advertised 54 positions in rural district clinics. 25 applications were received, 22 applicants showed up for interviews and 12 were offered positions.¹ According to Dr. Karki, less than 50% of those offered positions actually showed up for the district jobs.

What is partly responsible for these grim statistics is the fact that current Nepali medical schools are mostly for profit, and

they recruit urban students who can afford the high tuition fees but who carry no inclination to practice in rural settings. A second contributing factor is the staggering lack of medical resources and intellectual or professional development opportunities for new graduates if they choose to practice in rural areas.

Upon graduating fifteen years ago, Dr. Karki, like most other medical graduates in Nepal, left Nepal for specialty training in Boston. In contrast with his peers however, Dr. Karki returned to Nepal with a burning desire to improve his country's rural health care.

Four years ago Dr. Karki and a group of dedicated Nepalese physicians, supported by an international consortium of colleagues from twelve international medical schools (including the University of British Columbia, the University of Alberta and the University of Calgary), established a new health science university, called Patan Academy of Health Sciences (PAHS). PAHS is a privately funded, not-for-profit, autonomous, public institution dedicated to training doctors to practice socially responsible medicine.

Several core principles support this lofty goal: 1) An innovative admissions process with preferential recruitment of applicants from rural areas, including "health assistants" who have undergone pre-requisite science courses and basic training in curative and preventative medicine, and who have already served for two years in rural health clinics; 2) scholarship support for students from rural areas; 3) a rural community health project that all students will propose, develop and implement throughout the length of their program; 4) clinical training at Patan Hospital, an institution with a well established ethos of service to the poor and disadvantaged within the Kathmandu Valley, thus providing strong social-accountability role modeling from doctors and other health care workers, and finally 5) post graduate support

while working in the rural context, including regular continuing professional development supported by information technology and telemedicine.



While the Patan Academy has yet to accept its first class, nine-year-old Saraswoti Pariyar, a young orphan girl from the Jumla district in Nepal represents the kind of student that the Patan Academy hopes to benefit. She is currently receiving an education through Sonrisa Orphanage in Kathmandu, Nepal. Saraswoti is smart but

is in a disadvantaged position financially and socially (due to her low-caste status). Without scholarship support, Saraswoti would not be able to consider a career in the health sciences. (Photo by CA Courneya)

In May of 2010 PAHS, by welcoming its first fifty students, will begin the journey towards improving socially responsible medicine — answering the World Health Organization's call in 1995:

"...The obligation [of medical schools is] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve."

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For more information on PAHS visit the website (<http://www.pahs.edu.np>) or contact CA Courneya (3rd from left-front row) and David Powis from the University of Newcastle(4th from left- front row) leading an Admissions Workshop for faculty members of Patan Academy of Health Sciences Faculty. Dr. Rajesh Gongal (2nd from left-front row) is the Dean of PAHS. (Photo taken with CA Courneya's camera, by R. Sresthna)