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.

REFERENCES

1. Steinbrook R. Health care and the American recovery and reinvestment act. N Engl J of Med. 2009;360:1057-1060.
2. Manchikanti L, Hirsch JA. Obama Health Care for All Americans: Practical Implications. Pain Physician. 2009;12:289-304.
3. Marmor T, Oberlander J, White J. The Obama Administration's Option for Health Care Cost Control: Hope Versus Reality. Annals of Internal Medicine 2009 Apr 7;150(7):485-490.
4. U.S. Department of Commerce. Income, Poverty, and Health Insurance Coverage in the United States: 2007. Washington, DC: U.S. Government Printing Office; 2008.
5. Obama B. Affordable Health Care for All Americans: The Obama-Biden Plan. JAMA. 2008;300(16):1927-1928.
6. Medicaid Program – General Information[Online]. 2009 Jul 27 [cited 2009 October 27]; Available from: URL:http://www.cms.hhs.gov/MedicaidGenInfo/.
7. Congressional Budget Office. Evidence on the Costs and Benefits of Health Information Technology. Washington, DC: Congressional Budget Office; 2008.
8. Congressional Budget Office. High–Cost Medicare Beneficiaries. Washington, DC: Congressional Budget Office; 2005.
9. Neumann PJ. Using Cost–Effectiveness Analysis to Improve Health Care: Opportunities and Barriers. New York: Oxford University Press; 2005.
10. Howard DM. Using cost–effectiveness analysis to improve health care: opportunities and barriers. JAMA. 2006;295(8):943-944.
11. Congressional Budget Office. Budget Options. Volume 1: Health Care. Washington, DC: Congressional Budget Office; 2008.
12. Russell L. Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings. Health Aff. 2009;28(1):42-45.
13. Cohen JT, Neuman PJ, Weinstein MC. Does preventive care save money? Health economics and the presidential candidates. N Engl J Med. 2008;358:661-663.
14. Tengs TO, Adams ME, Pliskin JS, Safran DG, Siegel JE, Weinstein MC, Graham JD. Five Hundred Life–Saving Interventions and Their Cost–Effectiveness. Risk Analysis. 1995;15(3):369-390.
15. Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay–for–performance: from concept to practice. JAMA. 2005;294:1788-1793.
16. Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U *et al*. Pay–for–performance programs in family practices in the United Kingdom. N Engl J Med. 2006;355:375-384.
17. Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Care Coverage for All. [Online]. 2008 [cited 2009 Nov 1): Available from: URL:http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.
18. Holahan J, Blumberg LJ. Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform? Washington, DC: Urban Institute Health Policy Center; 2008.
19. Holahan J, Blumberg LJ. An Analysis of The Obama Health Care Proposal. Washington, DC: Urban Institute Health Policy Center; 2008.
20. White J. Competing Solutions: American Health Care Proposals and International Experience. Washington, DC: Brookings Institution; 1995.
21. Marmor TR. Understanding Health Care Reform. New Haven: Yale University Press; 1994.
22. Gawande A. The Road Ahead. The New Yorker. 2009 Sept 10.

Teaching Socially Responsible Medicine in the Himalayas: A Lofty Pursuit

Carol-Ann Courneya, MSc, PhD[a]

[a]Associate Professor, Department of Cellular and Physiological Sciences, University of British Columbia, Vancouver, BC

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? Arjun looked at me with troubled eyes and said, "Her chances are actually quite limited." He 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.

Correspondence
Carol-Ann Courneya, cacourneya@gmail.com

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 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 the 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."

REFERENCES

1. "Ad for 54 Physicians, but only 25 applied". Nepal Samacharpatra. 2006 May 21.

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)