

Colleagues...

Dr. Arjun Karki, Department Chief, Patan Hospital - Nepal



Dr Arjun Karki began his career of health care and innovation as a health worker in the hills of rural Nepal. After graduating from Tribhuvan University Institute of Medicine, Karki went on to study in the United States where he acquired Board Certification in Internal Medicine, Pulmonary Disease and Critical Care. Since returning to Kathmandu he has worked tirelessly with his colleagues to enhance the status of both clinical practice and medical education in Nepal.

After leading the establishment of an innovative school at Kathmandu University, Karki is now working with national and international colleagues to establish Patan University of Health Sciences (PUHS). On the cusp of being formally recognized by their national parliament, PUHS is devoted to addressing the remarkable health disparities affecting the portions of the population outside the Kathmandu Valley. Karki is currently Chief of the Department of Medicine at Patan Hospital.

TBB: For those of us who have never been there, could you describe Nepal, could you set the scene in terms of the environment, the social and political landscape?

AK: It's a country of mountains, as you know, the country of Mount Everest. Beautiful nature –that's what attracts a lot of tourists and once they are there most of the people want to go again and again. The people are extremely nice, mostly farmer population –hospitable, very friendly. At the same time there is also tremendous poverty. Until recently the country was in a mess of a bloody civil war; with the recent peace accord the likelihood of similar violent political conflict erupting has lessened so it's peaceful.

TBB: You say there's a lot of poverty –is there an image that stands out in your mind of how that poverty looks?

AK: First of all when we say poverty what are we saying? When a person does not have an income above a dollar a day then we define this person as being below the poverty line. When I say "poor" this is what I'm talking about. Over half the population in Nepal do not have an income that is equal to a dollar a day. The average national expenditure on health per person per annum is somewhere between 10 and 11 dollars.

Because we do not have insurance and the public subsidy is low what happens is about 70 percent of the costs

have to be borne by the individual patient or his/her family. So imagine people getting sick and not having any means to get medical care. Or they can't go to work so they don't have money for food when they need it most –they don't have resources available to feed themselves, to feed their kids,

to feed their families. So the suffering that accompanies having so little –the mental suffering, the physical suffering– this is what I'm talking about when I say "poor."

TBB: Could you tell the readers a bit about the similarities and differences between the medical systems that you find here in Canada and the United States and the one in Nepal.

AK: One of the commonalities would be the scientific aspect of it: when you have a patient come to you the protocol that you follow –the evaluation and treatment– would be similar. Other than that there is a big, big, contrast between the medical systems of North America and that of Nepal. First, we do not have any insurance system and therefore everything in terms of the treatment has to come out of pocket. The second thing is the misery of the general populace: there are poor even in urban areas where most of the health care system operates. Thirdly, there's the large misery in the rural areas where health care hardly exists. It is not only a question of affordability (which

is absolutely the case for rural people) but accessibility. In Canada and the US people talk about the shortage of doctors and medical personnel in rural areas but the situations cannot be compared.

TBB: What are the consequences?

AK: People are dying premature deaths from diseases that are easily preventable or easily treatable. A lot of children die prematurely and a lot of women die during pregnancy or delivery due to the lack of adequate care. Women end up with



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complications that would be easily treatable had they had the access to a proper medical facility, but because there is none the women may end up dying.

And to go into more detail: more and more people in Nepal now have access to TV, telephone, and newspapers. We leave and bring back the message of what is happening around the world. As a result, people have the opportunity to see the disparity between what they are supposed to have, what is possible and what they actually have. This is one of the reasons for the political agitation we've had. The rebels mobilized the masses, resulting in a bloody civil war that has killed nearly 15,000 people and has left many hundreds of thousands displaced. This is the indirect effect of this disparity between urban and rural health. Unless we properly address the legitimate interests, the legitimate concerns, of the populace then it's going to lead to another bout of violence.

TBB: The project that you're working on with Dr. Woollard, our Department Head can you describe a bit about that?

AK: Basically what we're saying is that given how the health situation is related to the other factors in our social life —poverty, social discrimination, political violence, etc— when you talk about improving the health of the rural population you cannot see this in isolation. It has to be seen in the broader sociopolitical context.

Secondly, the current models of medical education have not been able to produce doctors who are willing

to serve the deprived communities, especially in the context of going out and being in the rural areas. This is in part what has led to the situation that I spoke of earlier. If we really want to address this disparity, if we really want to make the health care system functional, if we really want to prevent premature death and suffering, then we have to get the people who are not only competent but are also caring, enthusiastic, and are motivated to go and serve in the rural areas.

The current model of medical education does not orient the students in this direction; we cannot expect anything out of the current medical education system. To get a different result we have to take a different path. What we're talking about is creating a medical school, a new health science university with the principle of what Bob [Woollard] would like to call



“socially accountable” —all of society has invested in and has so much trust in the doctors and in the health care system. If this is the case then we'd better try to do something that responds to all needs in society, especially those who are vulnerable, especially those who are voiceless.

TBB: What's the school going to look like in practical terms? What is the vision?

AK: Basically we would like to dedicate ourselves to creating an environment in which the health status of the

people of Nepal would be improved in a sustained way. Obviously, as I said earlier, we have to incorporate our programs in terms of education, service, research and collaboration with the other stakeholders; but in order to do that we first of all have to have an autonomous institution. It's what we're calling the Patan University of Health Sciences. Obviously the

scope and mandate of the university is going to be large. We would probably start with the training of the doctors and we envision a class size of about 50 per annum. It will be a course of five to six years.

There is also the concept of participatory development —how can we engage and work together with those who are supposed to be the beneficiaries of the work being done. We tend to knowingly or unknowingly use top-down approaches and that in part is what makes universities alienated from the real needs of the society, the real needs of the population. If we do not take into consideration the perspective of those who we profess to serve, then there's a greater risk of ourselves being alienated from the masses, from society. That is why we need to engage in a dialogue in a proactive way, and provide the opportunities for them to voice their concerns, to define the agenda together to whatever extent is possible. If we can bring them [the rural population] into a dialogue then we think we will help the cause even further: both from the perspective of sustainability in terms of the impact and of the cost effective use of the resources.

TBB: The question of participatory development —how is it integrated into the work being done in Nepal?

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AK: Here's an example: most of the medical schools, especially in our part of the world, when they develop this kind of program –let us say curriculum development– what ends up happening is that only the experts will sit in a room. They'll make a big conference, and then decide, "okay, we need to do this, this, this, this" and bingo, you have curriculum. What we've said is let's hear what the people have to say. What is it that they would like to see?

So we have involved people right from the inception. We're also engaging with the communities in the rural areas, encouraging them to identify persons who they think would have the capability to study medicine and also have the commitment to serve in their respective communities. We do not want to take the burden on our own shoulders alone. We want to involve the communities because they know what is in their best interest.

Obviously another context would be training our graduates so they already know the on-ground realities –we'll have students meet with the rural people to see and analyze the living conditions. What kind of food do they have? What is their income level? How do they manage their lives? Until and unless you expose your students to that reality then obviously you cannot presume that just by training them –by infusing them with the scientific concepts and certain skills –that they are automatically going to be socially responsible, socially accountable, doctors.

TBB: Do you have some specific examples that you could share?

AK: If our aim is just to treat the patient who will come to our office then that is a

relatively easy game. You wait in your hospital, let the patient come and visit you: then you treat those who come and ignore those who do not come. That's probably easy.

Whether it is accessible or not, that's an entirely different story. As I said, health is determined not by the technical part of the medicine alone. Injections are necessary; operations are necessary; drugs are necessary



–at times hospitalization and providing care in the hospital setting is important– but that alone and by itself is not going to improve health. Patients are grappling with issues such as food, security, income, water supply, and housing.

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TBB: What about these things, the water, the housing.

AK: People don't have water. Some people have to walk three hours one-way to get water –you can imagine how much physical labour they have to endure to do that. And what is

the amount of water they actually need to prepare food, to wash, to maintain body cleanliness, to clean the house, to use for the garden? And when you have the priority of drinking versus cleaning your toilet which one would you choose?

So this is what I mean by poverty. So telling them, "Keep your toilets clean. Wash your hands with soap and water each time you visit your toilet." This preaching alone is not going to do the trick. As physicians we have to explore how can we improve the water supply in this community? Who are the stakeholders who can contribute to improving the water supply in this area? Are there plumbers? Are there sanitary engineers in this area whose expertise we can tap? Your role as a doctor unless and until you are aware of this other dimension of health is limited. Whereas if you know, you would go and talk to the sanitary engineer, and negotiate with the government, or talk to the community leaders and say, "Hey guys, we have to improve the water sanitation in our community so that we do not suffer from the water-borne diseases."

If people do not have income, if people don't have economic opportunities, then it's difficult for them to get food, to build houses, to build latrines, to install tap water in their homes even if the water sources are available. It's not only financial resources it's a matter of mindset again. This issue is not exactly under the jurisdiction of a traditional physician. A traditional physician is supposed to be involved with taking care of a sick patient when they fall sick and not go beyond this.

If we really mean to improve the health of the people we have to go beyond that. For example, how can we motivate the children to go to school

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so that they learn and that knowledge comes into their families? Children can teach a lot of hygienic messages that are important –washing hands, letting the smoke go out of your home when you cook food otherwise you get some respiratory diseases. These may sound like small things, but when you are talking about a population of 24 million these small things can initiate a chain reaction –the way people think, the way people behave, and one thing can lead to another.

If poverty is creating that degree of ill health, then it becomes mandatory for you as a doctor, as a person who is committed to improving the health of that population, to take the leadership, to take the initiative, to spearhead the cause to improve the health. In order to be able to come to this phase of enlightenment or understanding and to have the confidence to go out and reach out to people for help, we need doctors and nurses with a completely different mindset.

TBB: When you consulted “the people” about curriculum development what did they say?

AK: What they say for example is “we don’t like the way the doctor talks to us. The doctors think of themselves as gods and we are nobody. They refuse to give us time when we ask questions. Teach your future doctors to treat us as human beings.” These are the kinds of things they told us in the meeting. So obviously when your curriculum does not emphasize this concept of respect, the concept of good communication skills, listening skills –we are what we are because of the education that we have, the way we are brought up.

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TBB: Are there any questions that I should have asked, but haven’t?

AK: You might like to ask how could UBC help?

TBB: Okay, how can UBC help?



Bob Woollard & Arjun Karki

AK: We would like to see three things from UBC. Number one is the fact that yours is an established institution with decades of experience. You have an institutional memory and institutional expertise –a system for doing things. This is one area we wish to learn and benefit from as we start building our own institution.

Similarly we need some help in human resources development –when you build an institution you have a tremendous need for faculty. We would benefit immensely from people on sabbatical with the academic interest and vigor to do international medicine

to come over and guide us –this would be a useful way to set up a department or a departmental system.

Thirdly of course would be the research area. We neither have the resources nor the research culture. It is the culture part that I’m interested: we could collaborate in identifying, developing and pursuing some mutually beneficial, mutually interesting research agenda, so that during that very process relevant technical know-how would get transferred to us. It is the local institutional capacity development that we are talking about. Similarly there is research that can only be done in Nepal. That may be of interest because the problems may have wider implications.

I would like to invite you and other colleagues to give careful consideration to the above-mentioned ideas and see what is realistically possible and what is not. Even at the human level, the person-to-person level, the friendships, the professional relationships, the cultural relationships are so gratifying and you’ll only know it when you are engaged in the process. You can ask Bob [Woollard] how he feels about it. For example, until recently he had never been to Nepal; now he’s traveled there three times and I think he finds the experience quite exciting. Such transformation is possible for other individuals as well. That is the charm of engaging in this international collaborative program. There are institutional benefits; there are national benefits; and there are individual benefits.

Contact:
drakarki@wlink.com.np