related to team-based medicine and "cultural competency" in the provision of health care to groups like the Aboriginal community are vital to eliminating regional variations in quality of care, adds Danielle Frechette, lead author on the report and RCPSC senior advisor, governance and policy development. "Why is it right that Canadians would have a different level of care in Ontario, than they might in say, Newfoundland?"

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Scully argues that harmonized licensure of new graduates, as well as standardized revalidation of existing and international physicians, and a national repository, would also vastly improve physician mobility, making it easier for doctors to jump jurisdictions to serve underserviced areas, or fill spikes in regional demand caused by emergencies.

Meanwhile, poaching by both wealthier provinces and urban centres, the report contends, could be allayed by modification of compensation models. Standardization would also curb the trend toward issuing restricted licences, which has become so widespread that it has "gone beyond the original intent of it being a mechanism used only in exceptional crisis circumstances," the report states.

But College of Physicians and Surgeons of New Brunswick Registrar Dr. Ed Schollenberg argues the barriers posed by mobility do not necessitate change that would undermine the ability of smaller provinces to recruit doctors to underutilized regions, particularly by using conditional licences to attract IMGs.

"That's all that we're arguing about really, at any particular time, 20%–30% of all physicians. I think the experience is it would be a pretty big problem for some locations if we had exactly one simple standard. Already, we lose physicians constantly to the centre of the universe [Ontario] and it would, in the long run, from a recruiting point of view, from a health delivery point of view, probably make things worse."

"From a health delivery point of view, it's hard to see an upside," Schollenberg adds.

Although Scully says Task Force Two isn't advocating the creation of a national body responsible for all licensing, it's not that great a leap once harmonized standards and a national repository are in place.

College of Physicians and Surgeons of Alberta Registrar Dr. Trevor Theman says such a notion shouldn't be rejected entirely out-of-hand. "From a public policy perspective, there's some appeal to that. But at the present time, it would be very challenging. ...[W]e've got the national and federal stuff and the provincial and territorial stuff, and we've got shared responsibility and shared roles. And really what you're asking is somebody to give up their responsibility and authority. Good luck." — Wayne Kondro, *CMAJ*

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Chronic malnutrition grips western Nepal

The combined effects of conflict and large-scale drought have led to a high rate of chronic malnutrition in western parts of Nepal, reports Action Contre la Faim (ACF), a France-based international, non-profit devoted to hunger relief.

ACF, which has 220 volunteers including doctors and nurses in 19 countries, came to this conclusion following a month of nutritional assessment in the north-western part of Nepal. It found that less than 15% of the population of some north-western regions had food stocks. The rate of severe malnutrition was 3.3% and overall malnutrition rate of the areas is 12.3%.

The worst affected are children. Benoit Miribel, director general of the ACF described the condition of children as "alarming."

"Malnutrition rates of children younger than 5 is 5 times higher than those in Darfur," he said at a media briefing in Paris.

In the north-western region, 60% of children have basic nutritional problems, there is a 40% rate of anemia and 40% iodine deficiency.

Nepal has been witnessing armed conflict since the beginning of Maoists' led "People's war" in 1996. The conflict has claimed 14 000 lives, destroyed infrastructures and severely affected the economy of poor rural communities. Compounding the problem is the fact that the north-western region experienced its worst drought in 40 years from February to March this year.

- 47% of the farmers have not been able to harvest and the remaining ones have only collected 25%-50% of their usual harvest
- 42% of Nepalese live below the poverty line and more than a third consume fewer than 2250 Kcal per day
- 60% of households of mountainous areas are not self sufficient, while agricultural production only covers food requirement for 3–8 months per year.

It will be even more difficult for them in the coming months as the next harvest is not expected until September, said Jean-Pierre de Margerie, acting country director of World Food Programme (WFP) Nepal.

In the 19 days of recent protest against King Gyanendra, road travel was severely curtailed and curfews were imposed in major cities making it very difficult for aid agencies to continue food distribution. The protests ended after the King restored multiparty democracy on Apr. 24 by reinstating the dissolved parliament and handing over sovereignty to the people. After the restoration of democracy both the government and Maoists announced a ceasefire.

"There is a ceasefire in Nepal. Now I hope the government and international community would ensure the smooth running of development programs without any hindrance," de Margerie said.

WFP Nepal is intensifying its program in the north-western part of Nepal and considering providing food assistance in these areas for the next 3 months, he added.

ACF is aiming to gather 15 tons of food to prevent the situation from getting worse. It appealed for 400 000 euros of aid to fund emergency programs. — Dr. Sharan Prakash Sharma, Nepal

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Darfur on life-support: MSF

"My team in Muhajariya Hospital is receiving truckloads of wounded. We just received another 44 cases of violent trauma last night [May 8] — most of them civilians," reports Vanessa Van Schoor, Médecins Sans Frontières head of mission (Dutch section) in Darfur.

The MSF team worked through the night operating on patients with gunshot wounds; 2 died.

"Tonight we have 84 patients in a 35-bed hospital. There is 1 surgeon."

Two years into the crisis, morbidity and mortality numbers are down to "manageable levels, but conditions in Darfur are like taking care of a patient on life-support," stated Van Schoor in an e-interview. "There is almost a complete dependence on international assistance; pull one of the plugs — the food, the medicines, the extra human resources — and it can quickly go critical again," stated Van Schoor, who has 4 Canadians in her mission.

The food plug may be pulled soon. Due to the on-going conflict farmers have left their property, harvests are small, and the World Food Programme does not have the resources to cover full food distribution. Malnutrition numbers are slowly increasing, confirms Van Schoor. Worldwide, 800 million people are affected by malnutrition (see page 1837).

MSF has been operational in Darfur since February 2004 and currently manages 170 expatriate and 2600 national staff at 10 sites. More doctors are definitely needed, says Van Schoor. MSF's target patient load is about 350 000, plus emergency responses. Last year, it treated 450 000, hospitalized 3028, operated on 1568, saw 45 813 in its nutritional centres and treated 310 for sexual gender-based violence.

When Kathleen Skinnider, a Victoria, BC registered nurse, arrived in Shariya in January, her mobile clinic's team had just evacuated due to fighting. "The first 4 weeks was pretty tense," she says. She worked in the front line around Shariya until April. The team saw 50 to 100 patients a day; the most prevalent problems were eye infections, coughing (suspected pertussis), diarrhea and malaria. "Generally the population was quite healthy," she reports, but she wasn't optimistic about the future.

"Food security and security go hand-in-hand with malnutrition," says Skinnider, who worked in a Darfur feeding station in 2004. — Barbara Sibbald, *CMAJ*

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Juan Carlos Tomasi

An MSF worker at the Zam Zam internally displaced person camp's therapeutic feeding centre in 2004.

Alberta health reforms shelved, again

Scant months after introducing their controversial plan to allow doctors to practise in the public and private system simultaneously and to allow Albertans to purchase private insurance to obtain quicker health care service, Alberta's governing Conservatives have been forced to essentially abandon the reforms until they iron out questions surrounding party leadership.

Skepticism about the merits of proceeding with the plan, both within caucus and the party's rural base; threats from Ottawa to withhold cash transfer payments from the province for violating principles of the Canada Health Act; and the earlier-than-planned retirement of Conservative Premier Ralph Klein combined to sink the proposal to allow simultaneous public and private practice.

Although Klein had vowed to implement the plan before retiring, the tepid endorsement he received as his party's annual general meeting advanced his retirement plans, leaving the thorny issue of whether to proceed with "Third Way" reforms to his successor.