ISSN: 2091-2749 (Print)
2091-2757 (Online)

https://doi.org/10.3126/jpahs.v12i2.89014

Interview with Professor Dr. Rajesh Nath Gongal

Madhusudan Subedi

Chief Editor
Journal of Patan Academy of Health Sciences (JPAHS)
Patan Academy of Health Sciences (PAHS)
Lalitpur, Nepal

Professor Dr. Rajesh Nath Gongal is an academic and healthcare leader whose career blends surgical expertise with visionary institutional management. As a Professor of Surgery at the Patan Academy of Health Sciences (PAHS), Dr. Gongal has played a pivotal role in shaping medical education in Nepal. He is deeply committed to developing innovative curricula that produce socially responsible health care professionals. His academic contributions extend to research, including studies on empathy development among medical students and palliative care awareness, reflecting his commitment to both clinical excellence and humanistic medicine. Dr. Gongal has held several key managerial positions: he served as Medical Director of Patan Hospital, later became founding Dean, Rector and Vice-Chancellor of the Academy. He is the Founding President of Hospice Nepal, the country's first palliative care center, and the Founding President of Nepal Ambulance Service, which introduced Emergency Medical Technician (EMT)-based emergency response through a three-digit number system. By initiating programs like Primary Trauma Care (PTC) training in Nepal, he has strengthened emergency medical preparedness across the nation. His academic leadership and managerial innovations have profoundly advanced Nepal's medical education, healthcare delivery, and emergency response systems. The *Journal of Patan Academy of Health Sciences* extends its sincere gratitude to Professor Dr. Gongal for his generous and thoughtful engagement in answering the written questions prepared for this interview.

Q.1. Could you tell us about your educational background and what inspired you to pursue a career in Medicine, and later in Surgery?

Answer: I completed my schooling at St Xavier's School in Kathmandu and Intermediate from Amrit Science College. I was fortunate to be selected under the Colombo Plan Scholarship to study Medicine. By strange hand of fate, of all the medical schools in India, I was destined to study in Darbhanga Medical College in Bihar, which was also the College that my Father had completed MBBS from. So, 25 years after graduation, he took me to his alma mater for admission. It took me eight long years to complete my studies- not because I failed, but because classes were frequently suspended sine die due to student infighting.

How to Cite: Subedi M. Interview with Professor Dr. Rajesh Nath Gongal. J Patan Acad Health Sci. 2025 Jun;12(2):98-107.

Correspondence: Prof. Madhusudan Subedi, School of Public Health / Dept. of Community Health Sciences, Patan Academy of Health Sciences (PAHS), Lalitpur, Nepal
Email: madhusubedi@pahs.edu.np

After returning to Nepal in late 1989, I worked in the Department of Surgery and Emergency at Bir Hospital. During that time, I completed the first part of the FRCS exam, which was then held in Kathmandu. This paved the way for me to begin surgical training in the UK in early 1992. There I successfully completed the FRCS from the Royal College of Surgeons of England on my second attempt.

I had always wanted to be a surgeon since my childhood. It must be because of my father. I had the opportunity to visit Bir Hospital from time to time and I found the operating theatre exciting. Later, I became interested in Palliative care and after completing my tenure as the Dean, I did a fellowship as well as an MSc in Palliative Medicine from Northern Ireland in 2015-2016. In 2019, I received a Fellowship from the Royal College of Physicians of Edinburgh.

Q.2. How did your professional journey begin at Patan Hospital? What were the key opportunities and challenges you faced as the Medical Director?

Answer: I worked in the UK for almost seven years and I enjoyed the time. The training was good. However, I never felt at home there. I had worked in Bir Hospital for two years before leaving for the UK. Although it was hard work and very challenging, I thoroughly enjoyed this time. I felt at home and everyone around me seemed like family.

After almost seven years in the UK, I decided to return to Nepal. In the process, I came in contact with Professor Dr. Jagdish Lal Baidya who was the Head of Department of Surgery at Patan Hospital and through him with Dr. Mark Zimmerman, the Medical Director who helped me join Patan Hospital in late 1998. It was probably the best decision of my life as it provided me with challenges and opportunities in health care delivery, hospital administration, health professional education and many other areas to grow.

I found the efficiency at Patan Hospital very similar to that of hospitals in the UK; we used to start surgery at 8 am on the dot and the list used to go on until 6-7 pm. There was no formal attendance system, as in the UK; however, everyone used to arrive on time.

Patan Hospital (PH) was run by United Mission to Nepal since its inception as Shanta Bhawan Hospital. Around year 2000, there was an indication that UMN would cease to run the hospital in few years. From that time onwards there was a lot of discussion on the future direction of the hospital. A group of physicians and several staff members including myself saw this as an opportunity to develop it into a Medical School as we felt that Patan Hospital was the right institution if we are going to produce technically competent as well as compassionate physicians because of the ethos that was embedded in Patan Hospital.

When we got a proposal from Kathmandu University Medical School (KUMS) to become their teaching site, this seemed an opportunity to realize our goal without too much investment. Lot of headway was made in this direction. To avoid repetition, I would like to refer to Dr Arjun Karki's interview where this process has been very well documented. When the talks fell through and Dr Arjun Karki joined Patan Hospital, we started the process of developing Patan Hospital to its own Medical School.

After UMN handed over the hospital to the Government and functioned as the Development Committee (*Bikas Samiti*), Dr Kundu Yangzom became Acting Medical Director. Initially I had no intention of taking up administrative responsibility, but because of the need to spearhead the process of transforming Patan Hospital into an academic enterprise, I decided to take the responsibility as a Medical Director in 2007. Although we had a Chief Executive Officer (CEO) in the hospital, the Medical Director was responsible for most of the major decisions.

As a Medical Director, I had two major challenges. One was to bring the hospital staff to a consensus to develop the hospital into an academic institution, and the second was to upgrade it into a modern thriving teaching hospital.

Within Patan Hospital, there was a group of people who were convinced that for long-term sustainability of the hospital, becoming an academic institution was the wisest path forward. Although Nepal had many medical schools, the rural-urban disparity remained very stark with most graduates disinclined to work in rural areas, the public trust in the medical profession was eroding as evidenced by regularly recurring anti-physician, anti-institution demonstrations and the majority of graduates opting to leave the country for greener grass. So, we felt Patan Hospital had that ethos which could be put to good use to develop a technically competent but at the same time a socially responsible and compassionate physicians. We also felt we had a responsibility to help reduce the rural urban disparity in health sector which was one of the reasons the nation had to go through the painful armed conflict of maoist insurgency.

There was also a significant opposition to the idea of becoming a medical school among staff, including many physicians. This barrier had to be broken. We were able to do this over time by involving staff in many training programs and many discussions, respecting many views that came across.

Regarding the second challenge, Patan Hospital was a very efficient hospital but also very basic. We had only basic lab, basic radiology with an X-ray machine, Ultrasound machine. We did not have CT scan. The operating theatre had only basic facilities. So, it was

very important to upgrade to match other hospitals in the valley. We were able to do this gradually.

Q.3. You are the founding President of Hospice Nepal, the first palliative care center in the country. What motivated you to establish this pioneering service?

Answer: During my years in surgery, I frequently encountered patients with advanced or metastatic cancer. Because surgical options were no longer feasible, many were discharged home without any support system in place. These patients often returned in severe pain, and it became painfully clear that our hospitals lacked a structured approach to pain management and psychological support. This gap troubled me deeply.

I shared my concerns with my colleagues, Dr. Pradeep Vaidya and Dr. Rajshree Jha from Teaching Hospital and with my college friend, Om Rajbhandary, who was in the business sector. Together, we recognized that palliative care was an urgent, under-served need and that we could meaningfully contribute without waiting for large-scale studies or long bureaucratic processes.

With this shared conviction, we opened a small palliative care unit in a private hospital in Maharajgunj called HM Hospital. We began with four beds and offered free services to patients, supported by the generosity of kind-hearted donors. Within six months, demand had grown so rapidly that we expanded to six beds. Even in this short period, the overwhelming need for palliative care became unmistakable.

When our initial arrangement ended, we moved to a more suitable facility on lease, where the service continues to operate today. Establishing this initiative remains one of the most significant decisions of my life. It has enriched us in ways I could never have imagined. Through our patients, we have witnessed immense suffering, but also extraordinary resilience and the profound sacrifices families make for their loved ones. These experiences have been deeply humbling and transformative.

Our outreach to rural areas further opened our eyes. We met patients who could not reach even the nearest healthcare centre—individuals with strokes, paraplegia, or advanced cancer who were confined to their homes without any care, people who were left behind by our health system as if they never existed. Some were left to deteriorate simply because they had no means or support to seek help. Being able to step into these lives and provide care has been one of the most meaningful aspects of our work.

Today, collaborative efforts between PAHS and Hospice Nepal has enabled rural health workers to visit patients in their homes, offering essential care and support. This approach has significantly improved quality of life for many, particularly those nearing the end of life.

The need for palliative care in Nepal is vast. The government must take decisive steps to integrate palliative services across the country. We are currently working with local and provincial authorities to strengthen services in Bagmati Province, and once this phase is complete, we hope to extend our efforts to other provinces.

Q.4. You are also the founding President of the Nepal Ambulance Service, the first to operate with Emergency Medical Technicians (EMTs) via a three-digit emergency number. What inspired you to create this service?

Answer: When I was a medical student, one night around 9 pm, my father—who was also a surgeon—and I were called to see my grandaunt. She had long-standing COPD and had suddenly developed breathing difficulties. When we reached her home near Kingsway, she was severely cyanosed and struggling to breathe. She needed to be taken to the hospital immediately.

We called an ambulance and helped her into it. The ambulance was dark, with no oxygen supply, no monitors—nothing more than a driver who assisted in placing the patient on a trolley and transporting her to the hospital. By the time we arrived, she had already taken her last breath.

That experience stayed with me for many years. I couldn't help but think that the outcome might have been different had the ambulance been properly equipped. Even if the outcome could not have changed, I felt there was no dignity in her last moments. I felt strongly that every patient—and every citizen—deserves better.

Later, when I returned from the UK and was working in surgery, I frequently encountered emergency and trauma patients, who I believed, could have survived had they received basic pre-hospital care on the way to the hospital. Simple interventions during transport can keep patients alive until they reach the emergency department. It became clear to me that emergency medical services required urgent improvement. At that time, we had already started Primary Trauma Care (PTC) training, the first of its kind in Nepal, and improving the ambullance service seemed to be the next step in improving emergency and trauma care.

Around 2007–08, discussions with friends and like-minded colleagues led to the formation of a group committed to improving ambulance services in Nepal. This group eventually became the Nepal Ambulance Service (NAS), and I was asked to lead the organization.

During this period, we connected with the Emergency Department at Stanford University, which had been supporting the development of a pre-hospital emergency service in India known as EMRI. They had already launched the three-digit emergency number 108 in Hyderabad. My colleague, Om Rajbhandary, also a board member of NAS, and I travelled to Hyderabad to observe their operations. We visited their highly efficient ambulance call centers and saw first-hand how a coordinated system could save countless lives.

We returned to Nepal inspired and determined to adapt these ideas to our context. With persistent effort, we succeeded in getting the government to allocate the three-digit emergency number 102 for ambulance services. We also secured support for establishing a centralized call center. Generous donors provided five advanced ambulances each valued at around NRs. 25 lakhs. Such support gave us the foundation we needed.

With the help of Stanford University, we developed Nepal's first structured Emergency Medical Technician (EMT) training program: six weeks of classroom teaching with scenarios and simulations, followed by six weeks of clinical rotations. I am immensely grateful to Professor SV Mahadevan and late Professor Paul Auerbach of Stanford University for helping to develop the Emergency Medical Services (EMS) in Nepal.

The Nepal Ambulance Service has now been functioning for nearly 15 years. During this time, it has transported more than 100,000 patients, conducted over 70 safe spontaneous normal deliveries en route, and played a critical role during national crises—including the 2015 earthquake and COVID-19 pandemic. During COVID, our ambulances were designated by the Nepal government specifically for transporting COVID patients. Our team members lived in hostels in isolation for months to provide uninterrupted services.

Today, the service is supported by Kathmandu Municipality and continues to offer free ambulance services to the public. One of the most positive outcomes of this work is that the Ministry of Health now recognizes EMTs as essential personnel for ambulances and has established national standards for ambulance services. Provinces are now required to have a unified call center linked to the 102 emergency number.

Despite this progress, much more remains to be done. We must continue strengthening the system so that people across the country can access timely and life-saving emergency care whenever they need it.

Q.5. As the founding Dean of the School of Medicine at PAHS, what were the major challenges to initiate the program and integrate Patan Hospital staff under the PAHS umbrella?

Answer: As the founding Dean of the School of Medicine, I saw not just challenges, but an abundance of opportunities for innovation, growth, and advancement in medical education. PAHS was an autonomous institutions and had the opportunity to develop an entire medical school from the ground up: developing the curriculum and implementation strategies, designing the admission processes, establishing teaching methodologies, setting up assessment systems, and training our faculty with all these new and innovative processes. In every sense, we were standing before a blank canvas. We held the brush in our hands, free to choose the colors and shapes, of course, within the norms set by the Nepal Medical Council and the internationally recognized standards of medical education.

Even within those boundaries, the canvas remained wide open. I believe very few people receive such an opportunity in their lifetime—the rare chance to help shape the future of medical education in one's country. It is truly a blessing. I believe that with the team of dedicated faculties, generous help from international faculties, we were able to create a beautiful masterpiece that is PAHS as it stands today, in my opinion a very unique institution in the country, perhaps in the world.

Having said that, we did have a few challenges at the start. The first challenge was establishing adequate infrastructure for teaching the Basic Sciences, and second was securing qualified faculties, which were scarce during that period. Remarkably, the preclinical building that is functioning today was completed in a record three months -- a feat many had considered impossible.

For delivering the Basic Science curriculum, we were able to recruit many young faculty members who believed in the PAHS mission. We were generously supported by our International Advisory Board which was able to recruit many Basic Scientists from many different parts of the world who volunteered their time at PAHS to help teach, guide, and mentor our faculty members. We are very grateful to each one of them. We also sponsored several physicians who wanted to pursue their career in Basic Sciences so that they could join PAHS as faculty on completion of their studies. Today, we have very dedicated and competent Basic Science faculties to passionately deliver the curriculum without requiring any help from international volunteer faculties.

Q.6. What were the opportunities and challenges PAHS faced in developing its unique entry criteria for medical students? How do you assess PAHS's criteria in comparison to the Medical Education Commission's standardized criteria for all academic institutions in Nepal?

Answer: The PAHS admission policy is something we should be immensely proud of. Although, now it is relegated to the history of PAHS, I think it is a true reflection of what PAHS stands for. In our country, many individuals, organizations and even government agencies talk about doing justice to the marginalized groups who were historically disadvantaged by the designation of so-called backward castes, or people of rural and remote regions. PAHS, however, has not only talked the talk but also walked the walk when it comes to providing opportunities and social justice to such communities.

The guiding principles were: i) academic qualifications alone was not enough ii) other important qualities like cognitive skills, empathy, morality, communication skills etc. needs to be included and iii) equity i.e. to give preference to the marginalized.

The Admissions Committee was established to design and implement a fair, context-appropriate admissions process, and as Dean, I was entrusted with leading this effort. The use of the Personal Qualities Assessment (PQA) and the Multiple Mini Interviews (MMI)—including the rationale for adopting these methods and the technical support we received from Professor David Powis and his team from the University of Newcastle has already been described by Professor Dr. Arjun Karki in his interview.

What I want to highlight here, is that we did not simply import a set of tests used in other countries and apply them unchanged to our setting. Instead, we undertook a careful, rigorous, and culturally sensitive validation process to ensure these tools were appropriate for Nepali students coming from diverse educational backgrounds.

We conducted several rounds of pre-testing with students from public and private schools, both within Kathmandu and from outside the Valley. We evaluated the English versions of the assessments as well as Nepali translations. After detailed analysis, we decided to use the English versions of the Mental Agility Test (MAT) while administering the Nepali versions of the MOJAC (Moral Orientation for Justice and Care) and ECAN (Empathy, Confidence, Aloofness and Narcissism), ensuring that language would not disadvantage capable applicants.

A similar level of diligence guided the development of our Multiple Mini Interviews—locally termed the "Admission OSCE." Each station, scenario, and scoring rubric was refined through repeated pilot tests and calibration exercises to confirm reliability and fairness. This careful validation ensured that the final admissions process not only reflected international best practices but was also firmly rooted in Nepal's educational, linguistic, and cultural context and did not disadvantage any group of students. It is also important to note that the interviewers we used for Admission OSCEs were not only faculties, but we also included staff from Administration and Nursing services. This was one of the ways to begin integration between Patan Hospital and PAHS. We also included interviewers from the community. We were of the view that the Community must also take responsibility in selecting the future doctors and also contribute to their training.

The final selection process combined the students' scores from the PQA and MMI, along with a Social Inclusion Matrix. This matrix incorporated important criteria such as Human Development Index of applicants' hometowns, residence in remote regions, prior health science experience (minimum two years), gender, Dalit and Janajati/Adiwasi status and public-school background. These were considered the indicators of positive discrimination. These social inclusion scores were added to the academic and interview scores of the students in partial and full scholarship categories to generate the final ranking.

Every step of this process underwent extensive discussion among faculty members, international experts and the academy leadership. The final admission policy was formally passed by the Academic Council. This policy became one of the most innovative and contextually relevant admission systems in Nepal.

A note of importance is our scholarship scheme system. PAHS was mandated to provide a full scholarship to 15% of the students. However, we went far beyond that to provide partial (half) scholarship to another 40% of our students. We also developed a provision of collaborative scholarship for a particular district to be sponsored by the local government or individuals.

However, developing the policy was only half the work. Implementing it, especially for the first cohort, was extremely challenging. As a new institution, we had to build the entire system from scratch: creating admission forms, designing verification procedures, and establishing a mechanism to confirm applicants' residency and social group status through local government documentation. Reviewing these documents was labor-intensive and time-consuming. We even had to train and orient the invigilators for the admission tests,mostly our own staff.

Even printing the question papers became a major challenge. Without our own printing press and hesitant to use external printing service providers

for confidentiality reasons, we relied on our internal photocopying machines. The entire question set was printed manually, and we completed printing just past midnight before the entrance examination.

We conducted the first PQA test in Little Angels School at Hattiban, Lalitpur. It was like a day of celebration with a large number of staff helping in the process. As the person ultimately responsible for the entire admission process, I must say I was a bit nervous but also very excited. The written examination went very smoothly.

For the PQA scoring, answer sheets had to be read by OMR Machine, answer keys collated and sent to Australia for evaluation. Once we received the results, we integrated them with the results of Admission OSCEs and Social Inclusion Matrix scores to finalize the selection.

Despite all the difficulties, the admission process went remarkably smoothly. The outcome was deeply satisfying: we were able to select a diverse group of students representing remote regions, disadvantaged communities, and various social backgrounds from across the country. It was a proud moment for PAHS, as our unique admission system successfully identified candidates who reflect the mission and values of our institution.

This process continued with minor modification through the years until the establishment of the Medical Education Commission (MEC) after which the admission process was done by one annual central national examination system. We lost our unique and socially responsive admission process; however, there were many provisions that we had included in the MEC admission system – the social inclusion matrix was partially included. Apart from test in science, MAT was also included in the assessment.

Although we were sad to lose the process we had worked so hard to develop, the centralization of the admission process by MEC had its own merits at the national level. The students now require to sit for only one qualifying examination annually for all Universities and Academias. The selection process is strictly based on merit. In addition to this, the fee structure and the scholarship scheme for Health Science Education are strictly regulated by the MEC.

Q 7. PAHS is recognized for its innovative approach to health professional education. What inspired you and your team to take this different path? In your opinion, how have these approaches impacted the students?

Answer: One of the most important reasons for establishing PAHS was our dissatisfaction with the quality of medical graduates being produced in the country at that time. The traditional medical education system followed a biomedical model that was highly disease-oriented. It was considered sufficient for students to know how to diagnose a disease and how to treat it. Our intention, however, was to produce not only technically competent health professionals but also individuals who are socially responsible and compassionate.

To achieve this, we deliberately adopted innovative educational strategies. This was the rationale for emphasizing problem-based learning, community-based education, clinical presentation–based learning, and periodic assessment, all of which have been well described by Professor Arjun Karki. In addition to these, we incorporated several other educational interventions into the curriculum to ensure that our students develop a broader understanding of the context and environment in which they will eventually work.

We believe that medical students must understand not only diseases, but also how illness affects individuals, families, and communities. One such intervention is the longitudinal patient follow-up program. In the first year, students are assigned patients with chronic diseases such as COPD, heart failure, renal failure, stroke etc. Working in groups of two or three, students follow these patients at home for a minimum of six months. They visit the patients' homes, interact with family members, and observe how patients cope with illness in their daily lives. This experience allows students to appreciate the impact of chronic disease beyond clinical symptoms. At the end of this period, students are required to write a reflective portfolio.

In the second year, students are assigned patients who are at the end of life, particularly those dying from cancer. Over the following six months, they are then assigned children living with disabilities such as Down syndrome, Autism, and Cerebral palsy. Once again, students document their experiences through reflective portfolios. We believe these experiences help students understand suffering in a much deeper way, going beyond mere symptomatology and treatment protocols.

Another important innovation is the nursing rotation. Before entering their clinical rotations, medical students work alongside nurses for one week, performing nursing duties such as patient care and medication administration. Students are often surprised by the complexity and responsibility of nurses' work. A study assessing the impact of this rotation demonstrated that students developed greater respect for nurses and their profession, which we hope will translate into better teamwork in their future practice.

PAHS is also the only institution in Nepal to include palliative care in both the MBBS and nursing curricula. This is particularly important, as a significant number of patients ultimately require palliative care as they approach the end of life. More recently, we have also incorporated medical humanities into both curricula. Several scholarly papers have been published evaluating the impact of these interventions.

There is a strong emphasis on reflective learning, students are required to write their reflections after important experiential learning like community posting, medical humanities and longitudinal patient follow-up.

Strong reflective narratives from students consistently demonstrate that these educational innovations have had a positive impact, helping students grow not only as clinicians but also as mature, empathetic, and socially responsive professionals.

Similarly, we took innovative approaches when designing the nursing curriculum with problem-based learning as the teaching and learning methodology. Medical humanities and community-based learning and education have helped the nursing students to gain a broader view of their work. Workplace-based assessments have ensured they are competent in their field of work.

Q.8. You were the principal architect of the medical humanities course at PAHS. What inspired you to initiate this course? What are the opportunities and challenges in expanding medical humanities to other academic institutions?

Answer: There seems to be a decline in empathetic, compassionate clinical encounters between patients and health professionals, not only in our country but all over the world. One could blame the individual health professionals for this, but that does not solve the problem. As someone who has been involved in medical education for long time, I feel that the problem is with our health education system. There is evidence that empathy actually reduces over time during medical education.

You see, we teach the lengths and breadths of anatomy, physiology, microbiology, and histology. We teach the pathophysiology and treatment of cancer. But when do we teach our students how to sit with a patient who has just received a cancer diagnosis? When do we ask them to consider what goes through a patient's mind as they lie in a CT scanner every six months, fearing recurrence? Or what emotions stir when we say, "There is no further treatment," and they begin to face the inevitable?

We teach about the symptoms of the disease and how to treat it. When do we teach the suffering caused by the disease? We talk about the pulmonary function test of a patient of COPD and become experts in analyzing the Arterial Blood Gas (ABG) but when do we discuss the fear, anxiety that the person might be experiencing when fighting to breathe in enough oxygen?

We teach how to perform Cardio–Pulmonary Resuscitation (CPR), the Basic Life Support (BLS), and the Advanced Life Support (ACLS) with utmost precision but when do we teach that sometimes it is okay to let go, that death is not a failure and that Death is not a medical event. Death and dying are never discussed. How then can we expect our graduates to understand what is going on in the mind of a person who is at the end of life or the pain the family is going through or their expectations? Without such understanding, it is obvious we as a profession fall short of peoples' expectation.

When do we talk about life, the purpose of life, the meaning of life and the value of life with our students? It is my belief these are equally important in medical education as all the other subjects we teach so well. There were also similar efforts going on in many institutions around the world.

So, when the six months' introductory block was removed (as the reason for continuing this was no longer there because of the centralization of admission process and students from health science background had to go through the same admission process) and we decided to have 8 weeks of Foundation block, I thought this was the right opportunity to include medical humanities in the curriculum which was accepted by all. The rich discussions that we have with our students about life, death and dying, suffering caused by disease and disability, aging, etc, using narratives, stories, poems, movies and paintings have not only helped our students grow but we have also learned so much from our students. I am thankful to you and Dr. Amanda Douglas for becoming a team to deliver Medical Humanities.

I believe the final reflections of the students, from both medical and nursing schools, prove that this has been a worthwhile effort. Now that we have completed MH in seven batches of medical students and two batches of nursing students, we are confident of the value this has added. We have a few publications as well. I think now it is the right time to highlight our effort and the value of MH to other Academia related to health professional education.

Q.9. You are the Founding Dean of the School of Medicine, former Rector and Vice Chancellor of PAHS. Reflecting on the current state of PAHS, which achievements are you proudest of, and which areas do you believe still need significant improvement?

Answer: I believe that PAHS is one of the best health professional education institutions in the world but every Vice Chancellor and other academic authorities will say that of their institution. However, it is not only me but many external faculties visiting PAHS and who understand the effort we are putting in to produce our graduates also echo the same.

It is hard to point out one particular area that one could be most proud of as I believe that moulding young minds to be what we dreamt our graduates should be like takes several interventions, some formal, some informal and some hidden. The combination of all these interventions over time is what sets PAHS apart from other institutions.

If you look at the School of Medicine, the Foundation Block of 8 weeks started in 2018 is unique to PAHS. The National Medical Commission of India mandated the Foundation Block since August 2019 in India and has also been practiced in several Medical Schools in South-East Asia. Inclusion of Medical Humanities in the curriculum in the Foundation Block since 2018 and its acceptance by the medical students gives me immense satisfaction.

PBL as teaching methodology has provided our students a base for lifelong learning and self-directed learning. I am sure it is more enjoyable than nonstop lectures. CBLE is common to many medical schools in Nepal but what is unique in PAHS is the level of engagement with the community. Our students live with the families in the villages during the first rural residential posting. The longitudinal patient follow-up during Basic Science Years is also very unique to PAHS. Similarly, the nursing rotation and integration of palliative care have added value to the curriculum. Similarly, the Clinical Presentation curriculum in clinical years sets us apart from other schools.

Our Assessment system is very different with a lot of focus on formative assessment with DOPS, CEX, CBD, etc. The summative examination is completed in one week. Likewise, the Common Interns Day during the internship in which areas of common interest are discussed with the whole batch of interns is also important in the growth of the students.

If one looks at the postgraduate program, PAHS is the only institution in the country running a competency based program in all the different specialities with much stress on formative assessment and EPAs (Entrustable Professional Activity) and system of continuous evaluation and feedback. The PG common academic day bringing all the residents together to discuss areas of common interest and cross cutting topics like ethics, research methodologies, professionalism, makes this a unique program.

School of Nursing and Midwifery was under the umbrella of Tribhuvan University and followed its traditional curriculum. Once Lalitpur Nursing College (LNC), as it was called, came under our umbrella, we implemented our own curriculum which again is unique in that we have PBL as teaching methodology which was implemented after rigorous evaluation by Health Professional Education Unit (HPEU). Medical Humanities, spread across the three years, Palliative care and Geriatric care are integrated into the nursing curriculum. Work Place Based Assessment makes our students truly competent.

The School of Public Health also runs MPH program with a competency-driven curriculum with close monitoring and mentoring of the students. Medical Humanities has also been integrated in the Public Health curriculum.

If you look at the hospital, what was once a 250-bed hospital when handed over by UMN is now 600+ multispecialty hospitals. We are at the verge of being fully digitalized paperless hospital. Patan Hospital will be the first governmental multispecialty hospital to reach this milestone. This has been the result of hard work over last 8 years with collaboration of IT team, administration and clinical staff. I am immensely grateful to Professor Dr. Paras Kumar Acharya for spearheading this project.

There are so, so many things to be proud of. I was also very proud about how our institution took leadership during the COVID pandemic. When other institutions were debating whether to admit COVID infected patients or not, we were ready to receive the patients with dedicated COVID dedicated ward, well equipped ICU with our own homemade PPE and well-defined protocols. It is during the time of national crisis that the collaborative and team work, the leadership and the dedication of all those who work and study at PAHS come to the fore.

There are always areas that need improvement. One such area is communication skill. Although we have given a lot of stress to this, there is ample room for improvement. I think the longitudinal spiral communication module which has recently been passed by the Academic Council for undergraduate program will to a certain extent help overcome some deficiency in this area. This module continues from the foundation block to the final year with increasing complexities and focus on gaining competence through role-playing.

Another area that requires attention is research. PAHS has been at the forefront of research that has made a significant impact on treatment modalities of common diseases like typhoid and the immunization schedule of children in the country in collaboration with Oxford University. However, it is still a challenge to develop a culture of research among faculty. With the functioning of the Research and Scholarly Activity

Committee (RSAC), I hope this will empower more faculty, residents and staff to conduct local context-based research.

Q.10. How do you envision PAHS contributing to Nepal's medical education system in the next 10–20 years, particularly in the fields of compassionate care and community-based palliative care?

Answer: Over the past 17 years, since its establishment, a great deal of sincere effort has gone into developing the three schools and the teaching hospital. In the initial years, considerable work was devoted to establishing the medical school from the ground up—finalizing the curriculum, designing and implementing an innovative admissions process, and putting in place the administrative systems required to run a medical school effectively.

Subsequently, the School of Public Health (SoPH) was established. SoPH is actively working to initiate a PhD program as a part of its academic expansion. The Academic Council of PAHS has already approved its intensive curriculum, ensuring a strong foundation for advanced public health research and training.

The School of Nursing was affiliated with Tribhuvan University. PAHS acquired it and significant effort is invested in strengthening and implementing its academic programs. It has been one of the best choices among the students.

From a very early stage, work also began on developing postgraduate programs, particularly the MD /MS curriculum. Designing and implementing a competency-based curriculum for all subjects—implemented for the first time in the country—was both highly daunting and deeply rewarding. To date, we have successfully completed several cycles of the MD/MS program.

We have completed the curricula for DM/MCh programs, which are also competency-based. What distinguishes these programs from those of other institutions is that they do not focus solely on subject-specific technical competence, they also emphasize broader dimensions of health, including health philosophy, humanity, public health perspectives, communication skills, and other essential attributes. We believe this holistic approach will help our graduates develop a broader and more balanced worldview.

So far, our efforts have been focused on developing our own programs and validating it. We have now reached a stage where we are able to share our experiences, achievements and our resources with other institutions. The new leadership must take this responsibility. It would be highly encouraging if other institutions were to adopt and adapt the innovations we have introduced, so that medical graduates across the country are not only technically competent, but also socially responsible and compassionate.

Q.11. The Government of Nepal is working to introduce an Umbrella Act for Health Sciences Academies. In your opinion, what opportunities and challenges might this Act present for PAHS?

Answer: In this day and age when our country has adopted a federal system with the view to decentralize power, why anyone would want to centralize well-functioning academic institutions is beyond me. I do not see any rationale in doing so. Some propound the principle of uniformity among the different academic institutions. Each of the Health Science Academias has its own unique background, history, environment, resources, opportunities and challenges. Wisdom dictates that one should take advantage of these uniqueness rather than trying to make them uniform. Uniformity, I believe, is the enemy of innovation.

A lot of effort has gone into developing a very unique educational experience at PAHS in all of its schools. The teaching hospital is functioning well. It will be a very sad day for PAHS if it has to let go of all its innovations in the name of a curriculum set by the Academic Council formed by the Umbrella Act for all Academia. We must, therefore, continue to educate policymakers to make rational decisions.

Q. 12. Many individuals and organizations have supported the growth and development of PAHS. Would you like to acknowledge any special persons or organizations for their valuable contributions?

Answer: Yes, you are absolutely right. We would not be where we are today—as an institution of which we can be justly proud—without the support of numerous individuals and organizations, both within the country and internationally. It is essential that we not only acknowledge their contributions but also express our deep gratitude to them.

First and foremost, we must acknowledge the founders of Shanta Bhawan Hospital, particularly Dr. Bethel Harris Fleming, who was inspired by her husband Robert Fleming who was an ornithologist and was lured to Nepal by a bird named Spiny Babbler (*Kande Bhyakur*) which was thought to be extinct but was found in Nepal by Ripley. This trip to Nepal opened his eyes to the stark lack of health facilities in Nepal and the suffering as its consequence. He convinced his wife Bethel, a gynecologist, who was stationed in Mussourie in India. They came to Nepal and established the several clinics and maternity hospital which later was shifted to a palace owned by Shanta Sumsher Rana and formed Shanta Bhawan Hospital. It was run by United Mission to Nepal, a group of missionaries from many countries. They were later joined by Dr. Frank A Joseph Miller, Karl

Fredricks and many others. They planted the seed that has grown into what is now the Patan Academy of Health Sciences. At a time when healthcare services in Nepal were extremely scarce, they provided much-needed care to the people. More importantly, they nurtured and institutionalized values and an ethos of compassionate care at Patan Hospital—values that later became the foundation upon which Patan Academy of Health Sciences was established.

We are also indebted to all those who contributed to the transition of Patan Hospital into Patan Academy of Health Sciences. This process has been well documented by Professor Arjun Karki. The National Advisory Board and the International Advisory Board played a pivotal role in shaping PAHS.

The National Advisory Board was led by Mr. Kedar Bhakta Mathema, former Vice-Chancellor of Tribhuvan University and included distinguished members such as Dr. Hikmat Bista, Dr. KK Pandey, Dr. Bhagwan Koirala and Mr. KB Rokkaya. The International Advisory Board was led by Professor Bob Woollard from University of British Columbia and Professor Cliff Tabin from Harvard University. These advisory groups were instrumental in helping us define our mission, vision and goals. In particular, they provided invaluable guidance in curriculum development, student admission processes, and faculty development. IAB in particularly also assisted us in recruiting volunteer international faculty members, especially in the Basic Sciences, at a time when such faculty were extremely limited within the country.

Our innovation was also supported by Nepal Medical Council (NMC) and we are grateful to Dr Som Nath Arjyal who was the Chair of NMC at the time. Similarly, we are also grateful to the community in Makwanpur district who accepted our students into their homes and their hearts like their own children and helped shape them into mature graduates who understand their country and the people.

We are especially grateful to Jim and Marilyn Simons. Words are insufficient to express our appreciation for their immense contribution to Patan Hospital. It is our hope that, as an institution, we have been able to offer them some comfort in their profound loss—the tragic death of their son, Nick. Nick had come to Nepal, fell in love with the country and its people, and wrote to his parents expressing his wish to one day study medicine and return to serve the people of Nepal. Sadly, while on holiday in Bali, he lost his life in a tragic swimming accident.

In their grief, Jim and Marilyn transformed their pain into a powerful commitment to help Nepal. Their involvement began with Patan Hospital where they gifted us the Nick Simons Maternity Block which has improved the obstetrics and maternity care significantly. I was the Medical Director during the completion phase of the Nick Simons building, overseeing both its construction and early operations. During this time, we developed a close friendship that has endured over the years. Regardless of my role—whether as Medical Director, Dean, Rector, or Vice-Chancellor—their support was unwavering. They consistently responded to every request for assistance, helping to equip the hospital and elevate it to a high standard of care.

Beyond this, they also supported the construction of the nursing hostel, which is now among the finest of its kind in the country. For their generosity, commitment, and friendship over many years, I remain deeply grateful. Unfortunately, we lost Jim in May 2024 but his indomitable spirit and his humility continue to inspire us.

Q.13. What message would you like to share with future leaders, faculty, and students of PAHS to help sustain its mission and enhance its impact?

Answer: PAHS is a truly unique and very special institution. It has been built through hard work, unwavering commitment and the sacrifices of many dedicated individuals. These collective efforts have shaped PAHS into what it is today—an institution grounded in a clear vision, strong values and a deep social mission.

What was once a mission, vision and goals written on paper has now been translated into real-time achievements in the form of three schools and a dynamic hospital. The leadership must continue to pass this vision forward to future generations of faculty members, administrators and students so that its purpose remains alive and vibrant. It is also important that we do not rest on our laurels but continuously seek to improve, as there are always areas for improvement

Teamwork lies at the core of PAHS. I have always believed in collective leadership. The institution has succeeded because people have worked together with trust, humility, and shared purpose. This spirit of collaboration is one of PAHS's greatest strengths.

Another defining characteristic that sets PAHS apart from many other institutions is its firm stance against allowing party politics to enter its gates. Every individual has the right to personal beliefs and convictions, but once we enter the gates of PAHS, our only goal is to work for our people and our patients and our students. It is therefore the responsibility of the leadership, the faculty, the staff and the students to safeguard this principle. Party politics can divide and weaken institutions. PAHS must remain a place where unity, service and academic integrity stand above all else.