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Interview

Interview with Professor Dr. Shrikrishna Giri

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Note from the Interviewer

Professor Dr. Shrikrishna Giri is a distinguished orthopaedic surgeon, academic leader, health regulator, and prominent figure in medical education reform in Nepal. His professional trajectory encompasses nearly four decades, traversing the full spectrum of Nepal's health system: from grass-roots rural service as a Health Assistant to specialist clinical practice, district-level health leadership, national policy formulation, professional regulation, postgraduate medical education, and culminating in his role as the founding Vice-Chairperson of the Medical Education Commission.

Raised in a rural family in Lamjung district, Professor Giri's early education was grounded in classical Sanskrit studies at home. The limited availability of modern medical care in his village, coupled with personal experiences of illness and the daily challenges of accessing schooling, instilled in him a lifelong commitment to improving health services for underserved populations. This foundation guided his path from the Health Assistant programme to the MBBS degree and eventual specialisation in orthopaedics.

Throughout his career, Professor Giri has demonstrated exceptional versatility. As the sole medical officer in remote Achham district, he managed major public health emergencies, including cholera outbreaks. His subsequent clinical roles in zonal hospitals during a period of political instability honed his surgical expertise and reinforced his adherence to medical ethics. At the national level, he contributed to key initiatives at the Nepal Medical Council, Nepal Health Research Council, Ministry of Health and Population, and National Academy of Medical Sciences, notably advancing ethical research standards and policies linking medical education to rural service needs.

In this written interview, Professor Giri offers candid reflections on his journey and articulates a clear vision for strengthening medical education in Nepal through enhanced quality, equity, and social accountability.

Keywords: Medical education in Nepal, Medical education commission, Nepal

We are truly honoured and grateful to have you with us. On behalf of the Europasian Journal of Medical Sciences, we sincerely thank you for your time.

Q.1. Professor Giri, could you describe your educational background and explain what inspired you to pursue a career in medicine, and later to specialize in MS Orthopaedics?

My educational journey began in a traditional rural setting. I did not start formal schooling from grade one; I joined school directly in grade three. Before that, my grandfather had arranged a teacher at home, and my early education was mainly in Sanskrit. His wish was to make me a Sanskrit guru and astrologer. Therefore, as a child, I studied classical Sanskrit texts such as Laghu Kaumudi, Vaswoti, Rudri, and similar books at home.

Although my professional life later moved toward modern medicine, I still consider that early Sanskrit education valuable. It gave me discipline, concentration, memory training, respect for knowledge, and a strong moral foundation. It also taught me that learning begins not only in classrooms but also at home, in family values, culture, and the realities of society.

Later, my father realized that I should receive formal school education. Initially the school was not very far from our home, but after my family migrated to our farming field, I had to walk about one hour to school. After I passed middle school, the higher-level school was even farther away, and I had to walk nearly two hours each way, almost four hours a day. For an ordinary person, that was almost a full day's work, but for me it became part of life. Those years taught me endurance, punctuality, patience, and the importance of education.

I completed my SLC from Shanti High School, Kunchha, Lamjung, in the first division. Throughout my school life, I remained among the highest-ranking students at almost every level. Coming from a rural background, this achievement gave me confidence that hard work, discipline, and family support could open doors to higher education.

My inspiration to enter medicine came from the painful realities of rural Nepal. During childhood, my brother and I suffered severely from dysentery. We were both very ill. At that time, there was no hospital or modern medical facility in our village. My grandfather treated us with herbal medicines, and fortunately we survived. However, many people in the village were not so fortunate. I saw people suffering and dying from cholera, malaria, tuberculosis, dysentery, and other diseases that could have been treated if proper medical care had been available.

There was a health post near my high school, and gradually I developed a strong desire to become a doctor. I wanted to treat patients, relieve suffering, and serve communities where people had little or no access to modern health care. With this aspiration, I came to Kathmandu and joined the Institute of Medicine. At that time, the MBBS course had just started in Nepal. Because facilities and institutional arrangements were still limited, we had to wait for about six months before formally joining the Proficiency Certificate Level in General Medicine, commonly known as the Health Assistant course.

Later, when I advanced in medical education and clinical practice, I chose orthopaedics because it is a field where timely and appropriate intervention can dramatically change a person's life. Trauma, fractures, deformities, disability, and musculoskeletal problems are common in our society, especially among poor, rural, and working-class people. Orthopaedics gave me the opportunity not only to treat injury but also to restore mobility, dignity, independence, and productivity. For me, medicine was never only a profession; it was a response to the suffering I had seen in childhood.

Q.2. You began your professional journey as a Health Assistant in various districts. Could you share some memorable experiences from those early years?

My professional journey in health service began as a Health Assistant, and those early years were extremely formative. They gave me practical exposure to rural health care, clinical decision-making, emergency management, maternal and child health, nutrition, and the real-life challenges of delivering health services in resource-limited settings.

After completing the Health Assistant course, I first joined the United Mission to Nepal at Amp Pipal Hospital in Gorkha, where I worked for about one year. Amp Pipal Hospital was an important rural hospital at that time, and working there gave me strong practical exposure. I learned basic surgical skills, including incision and drainage of abscesses, wound care, emergency case handling, treatment of common diseases, and clinical assessment when investigations and facilities were limited.

During my time at Amp Pipal, I openly expressed my ambition to become a doctor. I wanted to continue my education and serve at a higher clinical level. However, I realized that I would have to wait for a long time because senior staff members were to be supported for further study first, and the plan was to support only one candidate per year. Therefore, although I valued the experience very much, I decided to seek another opportunity that could bring me closer to my goal of studying medicine.

I then joined Save the Children Fund, UK, where I worked in maternal and child health clinics and health post support programs. This was another important turning point. I worked closely with mothers, children, community health workers, and local health institutions. I learned how malnutrition affects children, families, and communities, and how maternal and child health services can prevent illness and death at the community level.

Later, I joined government service and was posted to Chhinamakhu Health Post for a short period. Soon after, I was deputed from the government to Save the Children Fund in Dhankuta, where I worked for about three years. This period deepened my understanding of district health systems, health post functioning, community outreach, maternal and child health, and the limitations faced by rural health workers.

Looking back, my early years as a Health Assistant were not merely a transitional phase before becoming a doctor. They were the foundation of my entire professional life. I learned to respect frontline health workers, to value clinical observation, to work with limited resources, and to understand the suffering of ordinary people in rural areas. After gaining this broad field-level experience, I joined the MBBS program at the Institute of Medicine, Kathmandu, with even stronger motivation to serve patients and communities more effectively.

Q.3. From 1994 to 1996, you served at Achham District Hospital as the acting District Health Officer. What opportunities and challenges did you encounter while working at the district level? Could you please describe the scariest night you faced during a cholera outbreak in the district? What did you learn about leadership when you were the only doctor in an entire district?

After completing my MBBS, I worked for a short period in the Bhutanese refugee camp in Jhapa with Save the Children Fund, UK. That experience exposed me to humanitarian health care, organized service delivery in a crisis setting, and the importance of public health coordination. Soon after, the Government of Nepal posted me to Achham district as a medical officer. Although my formal position was medical officer, I also had to take responsibility as District Health Officer because there were no other doctors or public health officers in the district at that time.

Achham was one of the remote districts of the Far-Western region, now Sudurpashchim Province. Geographically, it was difficult, scattered, and underserved, with 75 Village Development Committees. Roads, communication, referral systems, trained human resources, and supplies were all limited. Working there was not only a clinical assignment; it was a test of leadership, endurance, public health understanding, and human commitment.

One of the most serious public health problems at that time was cholera outbreak. Cholera did not come only as a disease; it came with fear, stigma, misinformation, and helplessness. In many villages, people were so frightened that they would not even drink water. Oral Rehydration Solution, locally promoted as Nun-Chini-Pani, was a very effective life-saving remedy, but it was not easily accepted by the people. Some believed that drinking water would worsen diarrhoea. Some families would leave their homes during the daytime and stay in the forest out of fear, returning later to see whether the sick family member was still alive.

The scariest moments were during cholera outbreaks, especially at night, when severely dehydrated patients were brought to the hospital or reported from distant villages, and the available resources were very limited. As the only doctor responsible for the district, I had to decide quickly where to send staff, how to distribute ORS, how to manage severe dehydration, how to persuade frightened communities, and how to prevent panic from spreading. There were moments when I felt the weight of the entire district on my shoulders.

To respond to the outbreaks, I established oral rehydration treatment corners in affected villages. I mobilized paramedical staff and local health workers. We trained traditional healers to recognize danger signs, refer patients early, and encourage people to drink ORS or home-made rehydration solution. This was important because traditional healers had community trust. Rather than rejecting them, we involved them in the referral chain and awareness process.

Besides outbreak control, I conducted family planning programs in the district, including vasectomy camps and female sterilization services. I was the first person to introduce minilap surgery in Achham district, and I conducted family planning camps in different parts of the district. I also organized eye camps, including cataract surgery camps, to bring essential specialist services closer to people who otherwise had little opportunity to receive such care.

One incident during an eye camp remained very painful. An elderly lady died following retrobulbar lignocaine injection during the cataract surgery process. I was not directly involved in that procedure, but as the health leader responsible for the district, the responsibility of managing the situation came to me. It was an extremely difficult and sad moment. I had to handle the family, the community, the

surgical team, and the continuation of the camp with sensitivity and responsibility. That experience taught me the importance of preparedness, communication, patient safety, accountability, and crisis management in outreach services.

I spent almost two years in Achham as the single health leader of the district, treating patients in the hospital while also leading public health services across the district. The most important leadership lesson I learned was that leadership in health service does not begin from position; it begins from responsibility. When you are the only doctor in an entire district, you cannot wait for perfect conditions. You must act with whatever resources are available, listen to people, mobilize the team, respect local beliefs, and still guide the community toward scientific and life-saving practices.

Q.4. You worked as an Orthopaedic Surgeon in Bheri and Lumbini Zonal Hospitals. What were your key learning experiences during your tenure at these institutions? What was the most complex trauma case you handled there with limited infrastructure, and how did you improvise to save that patient?

After completing my postgraduate training in orthopaedics, I worked at Bheri Zonal Hospital in Nepalgunj as an orthopaedic surgeon. This was an important stage of my clinical career because I had to treat a wide range of orthopaedic and trauma cases in a resource-limited regional hospital. The hospital served patients from a large catchment area, including remote hill districts, the Tarai, and border areas. Many patients arrived late, often after traditional treatment, inadequate splinting, infection, open wounds, or complications.

At Bheri, I treated fractures, dislocations, open injuries, bone and joint infections, neglected trauma, deformities, and emergency cases. I worked day and night to strengthen the orthopaedic service. Many patients who clinically needed referral to a higher center could not go because of financial constraints. Therefore, referral was not always a practical option. I had to use clinical judgment and manage difficult cases with the resources available.

The major lesson from Bheri was that orthopaedic surgery in a regional hospital requires courage, discipline, sound judgment, and the ability to adapt. In an ideal setting, one may recommend advanced implants, intensive care support, or referral to a higher center. But in real life, particularly for poor patients, the surgeon must balance the ideal with the possible. I learned to rely on core surgical principles: resuscitation, wound care, debridement, fracture stabilization, traction, plaster techniques, infection control, pain management, and close follow-up.

While working in Bheri Zonal Hospita, I had developed a surgical technique of distal locking without an image intensifier for the treatment of fracture tibia, which was published later. This was the innovative technique where the imaging facility was not available to provide the advantage of interlocking intramedullary tibial nailing to the fracture tibia patient for early ambulation.

After about one year at Bheri, I moved to Lumbini Zonal Hospital. Compared with Bheri, Lumbini had relatively better facilities and human resources, but the clinical burden was very high. It was also a period of political instability and Maoist insurgency in Nepal. The social environment was difficult, movement was restricted, fear was common, and health institutions were often under pressure. However, for me, the hospital had to remain a neutral place of service.

In Lumbini, I worked hard to establish and strengthen the orthopaedic unit. I treated patients regardless of their political alignment, background, class, or social identity. To me, a wounded person was first a patient. The duty of a doctor is to save life, reduce suffering, and preserve function. During the conflict period, that principle was sometimes difficult to maintain, but it was also the most important ethical foundation of medical practice.

There were many difficult trauma cases, including road traffic accidents, open fractures, severe soft tissue injuries, neglected fractures, infected wounds, and patients who arrived late because of poverty, distance, fear, or transport problems. Some patients required referral, but they could not afford it. In such situations, we had to improvise responsibly: stabilize the patient, control bleeding, clean and debride wounds, use available fixation methods, apply traction or plaster when needed, prevent infection, and follow patients closely. The goal was always to save life first, save the limb second, and restore function as much as possible.

During that period, I also faced very difficult personal and professional experiences. Once, an Army official accused me of treating a Maoist combatant and I was arrested. For me, this was painful because I had never treated patients on the basis of political identity. Medical ethics does not allow a doctor to deny treatment to a wounded person because of politics, conflict, or social background.

Another incident remains very painful, and I do not like to remember it in detail. A patient with serious injuries from a road traffic accident died within about an hour of arrival at the emergency. The situation became tense. I was mishandled severely and left almost unconscious; even the ambulance was fired upon. I am fortunate that I survived. After that event, I began to feel that I was living a second life. I learned to value life more deeply and felt that whatever life remained with me should be used for the service of people and the nation.

Despite those difficult experiences, I received the trust and love of the people in Lumbini. I became a popular orthopaedic surgeon there because people felt that I was available, committed, and ready to help even in difficult circumstances. I treated many patients and helped prevent disabilities in many individuals who otherwise might have lost mobility, livelihood, or independence. Those years taught me that orthopaedics is not only about bones and joints; it is about mobility, dignity, family livelihood, and social reintegration.

Q.5. In 2011, you were appointed as an Executive Member of the Nepal Medical Council and as the Member Secretary of the Nepal Health Research Council. What were your major contributions and learning experiences in these roles? You served as Member Secretary of Nepal Health Research Council and initiated the FERCAP accreditation process, a WHO SEARO regional accreditation. Why was accreditation important for Nepal's research credibility? And what resistance did you face from those comfortable with the status quo?

My work in the Nepal Medical Council and the Nepal Health Research Council gave me the opportunity to contribute to two important areas of national health development: regulation of medical practice and strengthening of research ethics. These roles were different from hospital-based clinical service, but they were equally important because they were connected with professional accountability, public trust, and the credibility of Nepal's health system.

As Registrar of the Nepal Medical Council, one important policy I implemented was related to permanent registration of doctors who had studied under government scholarship. At that time, the country was investing public

resources to produce doctors, but rural and underserved communities were still facing a shortage of medical doctors. The policy required scholarship-bound doctors to serve in government-posted institutions, particularly in rural and underserved areas, before receiving permanent registration.

This was not easy to implement, but it was necessary from the perspective of social justice and public accountability. If the state supports medical education through public investment, the benefit should return to the people, especially those living in areas where doctors are not easily available. The policy helped ensure that doctors educated through government scholarship became available for government service and rural communities.

There was resistance in the beginning. Some young doctors felt that this requirement was restrictive, and some families and institutions viewed it as a burden. But I believed that the principle was correct. It was not meant to punish doctors; it was meant to connect medical education with national need. Over time, the policy became more accepted and contributed to making doctors available in government health facilities.

My role in the Nepal Health Research Council as Member Secretary was another important experience. During that period, I understood the importance of international credibility in health research, especially in ethical review. Nepal was conducting increasing numbers of health research activities, including clinical, public health, academic, and community-based studies. For Nepalese research to be respected nationally and internationally, our ethical review system needed to meet recognized standards.

I contributed to strengthening the Ethical Review Board of NHRC and worked toward compliance with FERCAP guidelines, which are linked with regional and international standards for ethical review. FERCAP accreditation was important because it helped demonstrate that our research ethics system could meet internationally recognized standards. For researchers, institutions, international collaborators, and funding agencies, accreditation provides confidence that studies conducted in Nepal are reviewed through a credible ethical system.

The process required improvements in documentation, meeting procedures, review quality, standard operating procedures, member training, conflict-of-interest management, record keeping, and continuing review. There was some resistance, as usually happens when a system moves from informal practice to structured standards. Some people felt that international accreditation requirements were too demanding or unnecessary. However, I viewed these changes as necessary for the long-term credibility of Nepalese health research.

My learning from NHRC was that research ethics is not an obstacle to research; it is the foundation of trustworthy research. Ethical review protects participants, researchers, institutions, and the country's scientific reputation. Both NMC and NHRC taught me that institutional reform is often difficult in the beginning, but if the purpose is clear and the policy serves the public interest, reform must be pursued with patience, fairness, and courage.

Q.6. You served as Chief of the Policy, Planning, and International Cooperation Division of the Ministry of Health and Population. What were your primary responsibilities and notable achievements during this tenure?

Serving as Chief of the Policy, Planning, and International Cooperation Division of the Ministry of Health and Population was an important opportunity to contribute at the national policy level. Until that stage, I had worked as a frontline health worker, district-level doctor and health leader, orthopaedic surgeon, hospital-based clinician, teacher, regulator, and research governance leader. The Ministry role allowed me to connect those field-level experiences with national planning and policy formulation.

One of my major contributions during this period was in the development of the National Health Policy. I contributed as Member Secretary of the policy drafting process. A national health policy is not merely an administrative document; it guides the direction of the entire health system. It must address service delivery, equity, access, quality, human resources, financing, governance, public health, and the changing health needs of the population.

In the policy drafting process, I tried to bring practical understanding from the field into the national policy framework. I had seen rural health problems closely in Achham, Dhankuta, Gorkha, and other settings. I had also worked in regional hospitals where poor patients often could not reach higher centers because of financial and geographic barriers. Therefore, I strongly believed that national health policy must not remain Kathmandu-centered; it should speak to the needs of people living in remote hills, rural districts, underserved communities, and areas with limited access to doctors and specialists.

Another important area of my contribution was in the development of academic health institutions in rural Nepal. I played a pivotal role in supporting the concept and development of institutions such as Karnali Academy of Health Sciences. For me, the establishment of such institutions was not only an academic agenda; it was a social justice agenda. Remote regions such as Karnali had long suffered from poor access to specialist services, weak referral systems, difficulty in retaining health workers, and limited opportunities for local students to enter health professions education.

The idea behind developing academic institutions in rural and underserved regions was to link education, service, and research with regional needs. If health sciences education is established closer to underserved communities, it can produce health workers who understand local realities, provide specialist services locally, strengthen district and provincial hospitals, and generate research relevant to remote populations.

This tenure strengthened my understanding that policy should emerge from the realities of the people. A policy becomes meaningful only when it improves access, reduces inequity, strengthens institutions, and creates long-term capacity within the country. That lesson later became very important in my work in medical education, regulation, accreditation, and national institutional reform.

Q.7. You worked as a Member of the Health Profession Education Commission, which was formed by the Council of Ministers of the Government of Nepal under the chairmanship of the Minister of Education. What were your key roles and responsibilities in this commission? What were the key learnings?

My involvement in the Health Profession Education Commission was one of the important institutional experiences of my career. The Commission was created at a time when Nepal was seriously discussing the need for reform in health professions education. There were concerns about quality, equity, affordability, regulation, student selection, institutional standards, geographic imbalance, and public trust. Therefore, the Commission carried a historic responsibility of preparing the draft of the National Medical Education Act 2075.

Later, as the founding Vice-Chairperson and executive

head of the Medical Education Commission, I had the opportunity to contribute directly to the establishment of the Commission as an institution. This involved building the Commission physically, administratively, financially, and technically. In the early period, the Commission did not have a fully developed office system, permanent human resources, institutional procedures, or operational mechanisms. Everything had to be built almost from the foundation.

My key responsibility was to translate the vision of the National Medical Education Act into practical implementation. An Act provides the legal framework, but implementation requires institutional structure, procedures, human resources, budget, stakeholder coordination, and public confidence. As the executive chief, I had to work with government ministries, universities, academies, professional councils, public institutions, private medical colleges, students, parents, experts, and political leadership.

During this process, I followed two principles. First, I believed in dialogue and fair dealing with all stakeholders. Reform cannot succeed only through authority; it requires communication, consultation, and trust-building. Second, I remained clear that there could be no compromise on quality, equity, and legality. Dialogue was necessary, but compromise against the law, public interest, or academic standards was not acceptable.

One of the major responsibilities was to support the implementation of core provisions of the National Medical Education Act, including regulatory mechanisms, procedures, entrance examinations, scholarship implementation, standards, seats and fees, and a more transparent and accountable system of medical education. These were not simple administrative tasks; they were reforms affecting powerful interests and long-established practices.

The key learning from this experience was that institutional reform requires both firmness and patience. If one is only rigid, reform may face resistance and isolation. If one is only flexible, reform may lose its purpose. Leadership must balance consultation with decision-making, fairness with firmness, and institutional discipline with human sensitivity.

I also learned that quality and equity must go together. Medical education cannot be judged only by the number of institutions or graduates. It must be judged by whether graduates are competent, ethical, socially accountable, and ready to serve the needs of the country. At the same time, access to medical education should not be limited only to those who can pay. Scholarship, geographic balance, public institution strengthening, and service responsibility are essential components of a just medical education system.

Q.8. You were appointed as Registrar of the Nepal Medical Council. How do you assess your role and the overall role of the Council in regulating medical practice in Nepal? As Registrar of Nepal Medical Council, you implemented a controversial rule requiring scholarship-bound doctors to serve two years in government-posted institutions before receiving permanent registration. You describe this as a "hard time"; what opposition did you face? Were you threatened? How did you withstand the pressure to achieve what is now a successful policy?

The Nepal Medical Council has a very important role in protecting the public by regulating the medical profession. Medical registration is not only a certificate for professional practice; it is a public assurance that the person who is allowed to treat patients has met required educational, ethical, and professional standards. Therefore, the Council must protect professional competence, ethical conduct, public trust, and the credibility of medical practice in the country.

As Registrar of the Nepal Medical Council, I considered my role both administrative and regulatory. The Registrar has to support the Council's decisions, maintain registration systems, implement rules, coordinate with institutions, respond to doctors and the public, and help protect the integrity of the medical profession. In a country like Nepal, where medical education and health services are closely linked with equity, access, and public investment, the regulatory role of the Council becomes even more important.

One of the most difficult but meaningful decisions during my tenure was the implementation of the rule requiring doctors who had studied under government scholarship to serve in government-posted institutions before receiving permanent registration. This policy was introduced because the government had invested public resources to educate doctors, while rural and underserved communities continued to remain without adequate medical doctors.

The implementation was not easy. Many scholarship-bound doctors and their families were unhappy. Some felt that the rule was restrictive, while others felt that rural posting would delay career plans or further studies. There were pressures, arguments, emotional appeals, institutional requests, and attempts to influence the process. It was a hard time because the policy directly affected young doctors at a sensitive stage of their career.

However, I believed that the principle behind the policy was correct. The rule was not intended to punish doctors; it was intended to connect public investment with public service. If the state provides scholarship support, the country has the right to expect some service return, particularly for rural communities where people may otherwise remain without doctors.

I tried to handle opposition with patience and clarity. I listened to concerns, explained the rationale, and remained consistent in implementation. Once a regulatory body starts making exceptions under pressure, the policy loses credibility. The support of law, institutional decision, and public interest helped me withstand the pressure. My own experience of working in remote districts gave me moral strength, because I knew what it means when a district or health post has no doctor.

Over time, the policy proved useful. Scholarship doctors became available for government service, and rural health institutions benefited from their presence. The policy also created an important message that medical education is not only a personal career opportunity but also a social contract. Looking back, I consider that period difficult but worthwhile. The role of a regulator is not always popular, but regulation must be fair, lawful, transparent, and guided by public interest.

Q.9. You also served as Registrar and Rector at the National Academy of Medical Sciences. What opportunities and challenges did you face while working in these positions?

My tenure as Registrar and later as Rector of the National Academy of Medical Sciences was another important phase of my academic and institutional career. NAMS is a unique institution in Nepal because it is closely linked with national hospitals, specialist services, postgraduate medical education, and the production of specialist human resources for the country. Working there gave me the opportunity to contribute not only to academic programs but also to institutional governance and national health workforce development.

As Registrar, one of my important contributions was in the formulation of rules and regulations of NAMS. At that

time, the Academy needed a stronger regulatory and administrative framework to guide its academic, institutional, and operational functions. I contributed to preparing and systematizing those rules and regulations, many of which continue to guide the functioning of NAMS even today. This was important because any academic institution requires clear rules, transparent procedures, and predictable governance to maintain credibility.

Later, as Rector, I had the opportunity to contribute more directly to postgraduate medical education and academic planning. One area I consider particularly meaningful was providing opportunity for doctors who had served in rural and remote communities to enter postgraduate education. Nepal needs specialists, but it also needs a system that recognizes and rewards doctors who serve outside urban centers. Therefore, I supported policies and admission approaches that encouraged rural service and created pathways for deserving doctors with field experience.

Another important contribution was the allocation of postgraduate seats to emerging institutions, especially Karnali Academy of Health Sciences. KAHS was being developed to serve one of the most underserved regions of Nepal. For such an institution to grow, infrastructure alone was not enough. It required faculty, specialists, academic leadership, and trained human resources. Therefore, significant postgraduate seats were provided to support KAHS in developing its future faculty and specialist workforce.

This was guided by a long-term vision. If Karnali was to have sustainable specialist services and academic programs, it needed its own trained human resources. Sending specialists from Kathmandu temporarily would not solve the problem permanently. Supporting KAHS through postgraduate seat allocation was therefore an investment in equity, decentralization, and future institutional capacity.

The challenges at NAMS were also significant. The Academy had to balance academic standards with service pressure in busy hospitals. Faculty workload, resident training, hospital crowding, limited infrastructure, coordination among multiple hospitals, and expectations from different stakeholders were continuous challenges. Introducing reforms in academic rules, admission priorities, and seat allocation also required careful consultation and institutional courage.

My learning from NAMS was that postgraduate education is not only about producing specialists; it is about producing specialists for the country's health system. Academic planning must be linked with national health workforce needs, rural service, institutional development, and equitable distribution of specialists. I feel satisfied that I could contribute to strengthening the regulatory foundation of NAMS as Registrar and to expanding socially responsive postgraduate education as Rector.

Q.10. You later worked as Vice-Chairperson of the Medical Education Commission, Nepal. As a former Vice-Chairperson, how do you evaluate the Commission's vision, current initiatives, scholarship provisions, and mandatory service bond policy? What areas would you prioritize for reform to further strengthen medical education in Nepal? What was the single biggest obstacle in those early days? And what kept you from walking away when coordination between government, academia, professional councils, and private colleges seemed impossible?

The establishment of the Medical Education Commission was a historic reform in Nepal's medical education system. Before MEC, governance of medical education was fragmented across universities, academies, professional councils, institutions, and government bodies. Entrance examinations, admission processes, fee structures, seat allocation, institutional monitoring, academic calendars, and standards varied across institutions. This created confusion for students and families, unequal standards, repeated financial and administrative burden, and public distrust.

The National Medical Education Act, 2075 and the establishment of MEC attempted to address these problems by creating an apex national body for coordination, regulation, quality assurance, merit-based admission, scholarship management, fee regulation, eligibility certification, institutional standards, and workforce relevance. I see MEC not only as a regulatory body, but as a national reform institution created to protect students, strengthen institutions, and serve the health needs of the country.

The vision of MEC should be to develop a nationally integrated, internationally recognized, ethical, equitable, and quality-oriented medical education system that produces competent health professionals committed to serving the people of Nepal. This vision must be quality-oriented, equitable, transparent, merit-based, nationally relevant, and internationally credible.

During my tenure as founding Vice-Chairperson, the most important task was to move the law from paper to practice. We had to establish MEC physically, administratively, technically, and financially. We had to build the Secretariat, mobilize human resources, develop procedures, coordinate with government and institutions, and begin implementation of the Act while protecting public trust.

The current initiatives of MEC, such as common entrance examination, matching, eligibility certification, institutional monitoring, standards, scholarship implementation, and accreditation-related work, are important achievements. They have shown that national coordination is possible. Students can compete through a common merit-based process, institutions can be brought under common standards, and public confidence can be gradually restored when the system remains transparent and legally grounded.

The scholarship provision is one of the most socially important aspects of medical education reform. Medical education is expensive, and without scholarship support, it can become accessible only to families with financial capacity. Scholarship provisions help talented students from diverse backgrounds enter medical and health sciences education. The mandatory service bond policy should be viewed in the same spirit. When the state invests in medical education, the benefit should return to the people, particularly rural, remote, and underserved communities.

However, scholarship and service bond provisions must be implemented fairly, predictably, and transparently. Students should clearly understand the terms, duration, posting mechanism, rights, responsibilities, and grievance pathway. The government should also ensure appropriate working conditions, supervision, security, accommodation where possible, and career encouragement for those serving under the bond.

The areas I would prioritize for reform are quality assurance and accreditation, digital governance, faculty development, research integrity, provincial equity, workforce planning, and financial sustainability. MEC must move from the establishment phase to the transformation phase: protecting what already works, correcting what remains weak, standardizing what varies across institutions, and digitizing what must be transparent.

The single biggest obstacle in the early days was coordination. MEC had to work with many powerful and diverse stakeholders: government ministries, universities, acade-

mies, professional councils, public institutions, private medical colleges, students, parents, faculty, political leadership, and civil society. Each had different expectations, histories, interests, and pressures. Building a new institution while implementing a reform law was extremely challenging.

What kept me from walking away was my belief that this reform was necessary for Nepal. I had seen the suffering of rural people without doctors. I had worked in district hospitals and regional hospitals. I had seen poor patients unable to access specialist care. I had also seen how unregulated expansion, weak standards, and commercialization could damage public trust. Therefore, for me, MEC was not merely an office or a position; it was a national responsibility. Dialogue was always necessary, but there could be no compromise on legality, merit, quality, equity, transparency, and public interest.

Q.11. Did you encounter any obstacles from political leadership, the private sector, or public institutions while implementing the MEC Act? What achievements make you most proud of your tenure as Vice-Chairperson of the MEC?

Yes, there were obstacles, and that was natural because the implementation of the MEC Act affected many established practices. Medical education is a highly sensitive sector. It involves public trust, student aspirations, institutional investment, professional standards, government responsibility, and private-sector interests. Any reform in such a sector is bound to face pressure, misunderstanding, hesitation, and resistance.

The obstacles came in different forms. There were expectations from political leadership, concerns from public institutions, resistance from private institutions, pressure from students and parents, and differences among universities, academies, and professional councils. Some stakeholders were worried about autonomy, some about financial implications, some about seats and fees, and others about legal interpretation. In the early phase, even basic institutional arrangements of MEC had to be developed while urgent decisions were expected.

The private sector had concerns because MEC introduced stronger regulation in areas such as seats, fees, admission, eligibility, institutional standards, and monitoring. Public institutions also had challenges because common standards and national coordination required adjustment in their existing systems. Universities and academies had their own traditions, rules, and academic calendars. Professional councils had regulatory mandates. Therefore, the challenge was not only opposition; it was also the complexity of bringing multiple systems into a coordinated national framework.

My approach was to maintain dialogue and fair dealing with all stakeholders. Reform cannot succeed through confrontation alone. We had to listen to institutions, understand genuine difficulties, and provide a clear pathway for compliance. At the same time, I remained firm that there could be no compromise on legality, merit, quality, equity, transparency, and institutional integrity.

The achievement that makes me most proud is that MEC was established as a functioning national institution from its initial stage. We contributed to building the office system, mobilizing human resources, arranging financial and administrative support, drafting procedures, and creating operational mechanisms. Establishing a new national commission is not easy, especially when it has to regulate a sector as complex as medical education.

I am also proud of the implementation of the common entrance examination and matching system. This was a major step toward merit-based admission and transparency. It reduced duplication, confusion, and uneven admission practices, and gave students a more predictable and nationally coordinated pathway.

Another important achievement was the strengthening of eligibility certification and related digital systems. A transparent eligibility system helps protect students, maintain standards, and support regulatory oversight. Digital systems also reduce informal influence and make services more accountable.

The scholarship system and service bond provisions were also major reforms. They helped link medical education with social justice and national service needs. Public investment in medical education should support the public health system, especially underserved regions. The purpose is not only to produce graduates but also to produce competent professionals willing and able to serve the country.

I am proud that MEC initiated and strengthened work related to standards, monitoring, and accreditation. Quality assurance is the heart of medical education reform. Without strong standards for faculty, infrastructure, hospital capacity, clinical exposure, curriculum, research, ethics, and patient safety, expansion alone may compromise quality. MEC created a national platform to move gradually from inspection-based regulation toward continuous quality assurance and accreditation.

My proudest achievement, therefore, is not a single decision. It is the institutional foundation of MEC itself and the public trust that began to grow around national coordination, meritocracy, and reform. The system is not perfect, and much remains to be done, but the foundation was laid.

Q.12. Professor Giri, what do you consider your unfinished work, and how have you planned to accomplish the work?

I consider the unfinished work of MEC as the transition from establishment to full institutional transformation. During the founding phase, the major task was to operationalize the National Medical Education Act, establish the Commission, develop basic procedures, initiate common entrance and matching, regulate fees and seats, implement scholarship and eligibility systems, and begin monitoring and standards-related work. These were foundational achievements, but a national reform institution cannot stop at establishment.

The most important unfinished work is to strengthen quality assurance and accreditation. Nepal's medical education system has expanded, but quality is still variable across institutions. Differences remain in faculty availability, clinical exposure, infrastructure, research environment, simulation facilities, student support, governance, and patient safety. MEC must develop a stronger accreditation roadmap based on institutional self-assessment, academic audit, monitoring indicators, and improvement plans.

The second unfinished work is digital integration. MEC has started online systems for entrance, matching, and eligibility, but the future requires an integrated digital governance platform. Entrance examination, eligibility certification, matching, student database, institutional monitoring, accreditation tracking, grievance handling, and reporting should be gradually connected. Such a system will reduce delay, improve transparency, protect records, support data-based decisions, and increase public trust.

The third unfinished work is faculty development. The quality of medical education ultimately depends on teachers, mentors, supervisors, researchers, and academic leaders. MEC should work with universities and academies to develop a national faculty development framework cover-

ing teacher training, continuing professional development, digital education skills, assessment methods, research mentorship, academic leadership, and faculty exchange.

The fourth unfinished work is competency-based and socially accountable education. Graduates must be clinically competent, ethical, communicative, team-oriented, research-aware, and responsive to Nepal's health needs. Curricula and assessment systems should emphasize clinical skills, patient safety, professionalism, community exposure, emergency care, public health, referral systems, leadership, and evidence-based practice.

The fifth unfinished work is research integrity and innovation. MEC should coordinate with NHRC, universities, academies, and professional councils to promote research mentorship, institutional review committee strengthening, plagiarism control, publication ethics, multidisciplinary research networks, and research linked with national health priorities.

The sixth unfinished work is equity and national health workforce planning. Medical education institutions, specialist services, faculty, and advanced academic resources remain concentrated mainly in urban centers. Karnali, Sudurpashchim, and other underserved regions still need stronger academic and specialist capacity. MEC should support province-wise analysis of programs, seats, specialist training, and health workforce needs. Scholarship policies, institutional expansion, postgraduate seats, and service bond mechanisms should be linked with underserved regions while maintaining merit and quality.

The seventh unfinished work is financial and institutional sustainability. MEC's responsibilities will continue to expand. It needs a permanent staffing strategy, infrastructure planning, digital maintenance budget, accreditation capacity, staff welfare planning, retirement-liability planning, and transparent financial governance. Reforms should not depend only on one office-holder. MEC must develop manuals, standard operating procedures, digital records, reporting formats, division-wise responsibilities, and succession capacity.

My plan to accomplish this unfinished work would begin with a focused first 100-day agenda: a MEC status and reform-gap report; review of entrance, matching, and eligibility systems; a digital integration roadmap; structured consultations with universities, academies, professional councils, students, faculty, and government; a quality assurance and accreditation action brief; a financial sustainability framework; and an internal responsibility matrix.

The four-year plan would be phased. Year One would focus on institutional strengthening, regulatory review, SOPs, digital service improvement, grievance standards, and financial sustainability planning. Year Two would focus on quality assurance, accreditation, academic audits, faculty development, and competency-based curriculum orientation. Year Three would focus on research promotion, innovation, national integration, and provincial academic collaboration. Year Four would focus on international recognition, WFME-aligned benchmarking, sustainability, and final evaluation of reforms.

In summary, my unfinished work is to help MEC become a stronger, digitally enabled, quality-oriented, equitable, accountable, and internationally respected institution. The ultimate goal is not simply to produce more graduates. The goal is to produce competent, ethical, socially accountable, and service-oriented health professionals who can strengthen Nepal's health system and serve the people of Nepal.

Finally, I would like to express my sincere gratitude to the interviewer, Prof. Subedi and Dr. Amgain, the executive editors of Europasian Journal of Medical Sciences (EJMS), and the publisher for providing me with this valuable opportunity to share my personal and professional experiences. It has been a privilege to reflect upon and communicate the journey, challenges, and lessons that have shaped my career and academic life. I sincerely appreciate the interest shown in my work and experiences, and I hope that the insights shared in this interview may be meaningful and beneficial to readers, researchers, and future generations of scholars.

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