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Interview with Professor Dr. Ramesh Kant Adhikari

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Professor Dr. Ramesh Kant Adhikari is widely recognized as one of Nepal's most respected pediatricians, educators, and public health advocates. His career has spanned more than four decades, during which he has combined clinical expertise with academic leadership and a strong commitment to ethics in medicine. He served as a Campus Chief of Maharajgunj Medical Campus and Dean of Institute of Medicine, Chairperson of the Ethical Review Board of Nepal Health Research Council, and Academician of Nepal Academy of Science and Technology. He continues to serve as chairperson of National Immunization Advisory Committee. In these roles, he was instrumental in strengthening institutional governance, expanding postgraduate programs, and embedding research into medical training in Nepal. As a mentor, he guided generations of medical students and faculty members, instilling in them the values of academic rigor, ethical responsibility, and service to society. Equally important is his lifelong advocacy for ethics in medicine. The Journal of Patan Academy of Health Sciences extends its sincere gratitude to Dr. Adhikari for his generous and thoughtful engagement in answering the written questions prepared for this interview.

Q.1. Could you describe your educational background and what inspired you to pursue a career in Medicine, and later to specialize in Pediatrics?

Answer: I was born in August 1949 in Duradanda, Lamjung. However, my family moved to Kathmandu when I was 5 years old. I attended schools in Kathmandu and passed the School Leaving Certificate (SLC) examination from Juddhodaya Public (JP) High School, one of Nepal's oldest schools, in 1964. I did my Intermediate in Science (ISC) from Public Science College (now Amrit Science College) in 1966 and bachelor's in science from Tri-Chandra College in 1968. I had the opportunity to learn from well-known teachers of those days.

I received a scholarship under the Colombo Plan from Government of India and joined Darbhanga Medical College in 1968. However, due to some legal case concerning admission policies in medical colleges in Bihar that year, the classes only began in February 1969. There were several unfortunate incidents during our time, including violent conflicts between different groups and Jayaprakash Narayan's agitation against the corruption and misgovernance of Indira Gandhi's government in 1974-75, which delayed our graduation. I completed my MBBS in July 1975.

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I didn't have a personal inclination toward becoming a doctor; rather, my family background and my father's wishes played a prominent role. My grandfather was an Ayurvedic Kabiraj and that might have played a role. My parents were probably motivated by their belief that medicine offered a safe option for employment later in life.

My reason for joining pediatrics was rather mundane. I felt very uncomfortable when dealing with infants and children as patients, and I became nervous when faced with a crying child. To improve my skills in this area, I decided to pursue a six-month junior residency in pediatrics. However, the experience and the guidance of my professor motivated me to choose this specialty more seriously.

I initially enrolled in the Diploma in Child Health (DCH) program at Darbhanga Medical College while simultaneously applying for an MD program at various colleges in India through the Indian Embassy. When I received the letter of acceptance from the All India Institute of Medical Sciences (AIIMS), New Delhi, I discontinued the DCH program and joined AIIMS.

There was neither an opportunity nor a need for me to take up a government job or any other employment before continuing my education.

Q2. How did your professional journey begin at the Institute of Medicine (IOM), Maharajgunj Campus, the first medical college of Nepal?

Answer: I was looking for a job in 1979 after returning from New Delhi with a postgraduate MD in Pediatrics from the AIIMS. I visited the Institute of Medicine to explore opportunities there. The then Dean of IoM, Dr. Hemang Dixit, offered me a lectureship in the Community Health Department of Maharajgunj Campus, as that department was facing an acute shortage of teachers. During the initial years of IoM, there were only two departments: Hospital Medicine and Community Medicine. I was assigned to teach subjects related to nutrition, sanitation, and hygiene. My later involvement in the field of nutrition has its origin in that initial exposure and appointment.

Q3. You served as Deputy Director of the Health Learning Materials Center at Maharajgunj Campus (1984–1999). During that period, the Center played a pivotal role in academic activities. Could you elaborate on the major roles and responsibilities of the Center and its contributions to medical education?

Answer: Those were the days when health services were being geared toward achieving the goal of "Health for All by 2000" through primary health care, as called for by WHO. Nepal was one of the countries committed to that goal, and health professionals required training to make it a reality. It was recognized that there was a great need for appropriate, relevant, and practical learning materials for health professionals working at the basic and middle levels of health institutions. Thus, a WHO-funded Health Learning Materials Project (HLMP) was planned under the aegis of the Institute of Medicine. Later, when the project period ended, it was converted into a center by IoM and renamed the Health Learning Materials Center (HLMC).

As per the New Education System Plan of 1972, IoM was given the responsibility of producing health workers to staff all categories of health institutions, which proved to be an appropriate decision. HLMC played a crucial role in producing textbooks and related materials required for training in public health, nutrition, midwifery, and primary health care. These books were made available to IoM students at half price. Its most popular publication was Doctor Nabhayema, a Nepali translation of David Werner's Where There Is No Doctor. The income generated from selling this book was used to construct offices for HLMC, where the Department of Pediatrics of TU Teaching Hospital is currently located.

HLMC also produced guidelines for writing manuals for health workers. It was recognized as a WHO Collaborating Center for Health Learning Materials, and Dr. Hemang Dixit and I were involved in offering advice for establishing similar centers in Sri Lanka, Thailand, Sudan, Kenya, and other countries. Later, HLMC was merged with the National Center for Health Professions Education at the Institute of Medicine.

Personally, working for the center gave me opportunities to write and publish books on child nutrition, child health (both in Nepali and English), and medical education. Some of these books continue to be published even after more than three decades

Q4. As Coordinator of the MD in Pediatrics Program (1997–1999) at Maharajgunj Campus, what key opportunities and challenges did you encounter in developing and implementing the postgraduate program?

Answer: Postgraduate programs such as MD/MS at IoM were initiated in 1993 through collaboration between government hospitals, including Bir Hospital and Maternity Hospital, and TU Teaching Hospital, under the aegis of the Postgraduate Medical Education Coordination Committee (PGMECC) with support from the Ministry of Health. At that time, PGMECC did not consider pediatrics an important discipline in terms of the human resources needed for the country. It was assumed that the one-year Diploma in Child Health program was adequate for the time being. TU Teaching Hospital did not have pediatric beds, and the number of beds and specialties at Kanti Hospital was considered insufficient to support an MD program.

In 1996, the Department of Child Health at IoM established collaborative relationships with the University of Bergen in Norway and the AIIMS, New Delhi, for research on child health. A trial conducted in Bhaktapur under this arrangement was considered a success. When collaborators from these three institutions met at the completion of the project to discuss future programs, the issue of human resources for research was raised, and the need for an MD program in pediatrics was recognized as a minimum requirement. It was decided to approach NUFU and the University of Bergen for support, and our request was approved. We were assured of funding for three students each year for three years, along with assistance to establish library and internet facilities for the program and training opportunities for our faculty at AIIMS. We also consulted the Department of Pediatrics at Patan Hospital, requesting their participation in the training program, and thankfully, the hospital management agreed. With these arrangements in place, we prepared the curriculum, sought approval from the subject committee at IoM, and received permission to start the MD program in pediatrics. This program was established outside of PGMECC.

Our collaboration with Patan Hospital involved posting residents there for six months and offering visiting professorships to senior pediatricians. This arrangement continued until the establishment of the Patan Academy of Health Sciences in 2008. Residents from the initial batches of the MD program fondly recall their experience of working in a better organized and disciplined environment. We faced further challenges in finding training opportunities in subspecialties such as cardiology and neurology, which were managed with support from adult specialists.

The resources we received for library and internet facilities were utilized to make internet access available to all departments at TU Teaching Hospital. This aspect of our collaboration was hailed as an example of optimal resource utilization, and we continued to receive support from NUFU for our research activities. The legacy of this collaboration still exists today in the form of the Child Health Research Project under the Department of Pediatrics, even after 30 years.

Q5. During your tenure as Campus Chief of Maharajgunj Medical Campus (1999–2002), what opportunities existed for academic innovation, and what administrative challenges did you face?

Answer: The major challenge we faced during that period was the lack of a hostel for girls. We solved this problem by constructing a block above the dining hall of the boys' hostel, with a separate access to ensure privacy. In addition, we negotiated with the Dean's office to facilitate the use of available space in the Nurses' Hostel. The solution was not perfect, but it helped to mitigate the problem.

There was also dissatisfaction among some faculty members who held only diplomas in their specialties, which limited their career progression. We had to improvise an academic program that would allow them to pursue further education leading to qualifications necessary for promotion to senior faculty positions. Under the guidance of the Faculty Board of IoM and the Academic Council of TU, master's programs in certain clinical specialties were created, enabling faculty members to pursue the courses while continuing their hospital work. It was an unusual approach, which was terminated once all such faculty members had completed the program. The then leadership asked the Faculty Board of IoM to resolve this impasse. Dr. Hari Govind Shrestha, the Dean of IoM, and Academic Assistant Dean Dr. Mohan Raj Joshi proposed a solution, and the concerned departments prepared curricula that were approved by the Faculty Board and the Academic Council of TU. Some graduates of this program later went on to serve in important roles within the university and the medical field.

Proper utilization of space for academic activities was another challenge I managed during my tenure. For example, I shifted the Community Medicine Department to the new academic building by reallocating rooms that had been assigned to the Campus Chief's office.

I also recall the role I played in clearing unusable vehicles that cluttered the parking area and removing junk that had accumulated over the years. With the help of supportive administrative colleagues, we were able to clean the campus. I did not have prior administrative experience, and that helped me approach colleagues in administration with openness, which allowed them to guide me effectively.

We had to send students to Bir Hospital for post-mortem examinations and demonstrations, where the facilities were rather primitive. The new academic building had facilities for post-mortem examinations for use by the Department of Forensic Medicine. Our team wanted to move the activity to the new facility; however, there was fierce opposition from the basic science faculty who shared the building with Forensic Medicine. In addition, local residents in the neighborhood opposed it. We had to create a new access route to the post-mortem room and convince the locals of the need for such a facility in our building. The resistance from faculty was eventually overcome through a series of consultations and careful persuasion.

Q6. You served as Dean of the Institute of Medicine, Tribhuvan University, from May 2002 to November 2007. Maharajgunj Campus was widely regarded as one of the leading community-oriented medical colleges in South Asia during that period. In your view, what factors contributed to this success, and what may have led to challenges in sustaining such community-focused programs over time?

Answer: Thank you for reminding the role Institute of Medicine had played in shaping the medical education in this country. The role of Institute of Medicine in designing a country specific program was highlighted in a WHO, SEARO publication in 1993 titled "Innovative Programmes of Medical Education in South-East Asia" edited by NM Mattock and P. Abeykoon. We must remember the pioneer Deans Dr. Moin Shah, Dr. Hemang Dixit, Dr. Gopal Acharya, Dr. Madan Upadhyay and Dr. Bhisma Prasai for their role in guiding the establishment of Institute of Medicine in its initial years.

Dr. Mathura Prasad Shrestha was entrusted with the task of conducting district health surveys to advise the institute to identify the type of doctors the country needed and what should be objectives of the educational program. It guided the admission policy and curricular content of the program. However, as most of the practicing physicians in the country were products of traditional medical curriculum prevalent in the region, there was not much support for the initiative. WHO and international agencies helped in getting the program off the ground with the relentless effort of the pioneer faculty whom I have mentioned above.

Institute of Medicine was established in 1972 under the new education system plan, and it was entrusted with the task of producing human resources of all categories from basic, middle to graduate level. Training programs under Ministry of Health were shifted to IoM. It started MBBS program in 1978. There was some skepticism among the medical community that a program which promoted community health and had a different admission policy would work and produce competent doctors. The entrants to the program were" in-service" candidates who were trained as middle level health workers (health assistant, staff nurse, pharmacists, radiographers, ayurvedic health assistants etc) and served at least for three years in the field. The curricular component in community health occupied more than 25% of the duration and it included community diagnosis and posting. It implemented an integrated curriculum which included problem based and self-directed learning. The first batch enrolled 22 students, and they graduated in 1984. IoM had invited professors from India and Canada as examiners for this batch of students. Dr. John Dickinson from Shanta Bhavan Hospital and later Director of Patan Hospital had written a brief article about the performance of these students in "The Lancet" praising the performance of the students. Many of the graduates went to serve in important positions later in the government and academia. Dr. Arjun Karki, founding VC of PAHS was the graduate from the second batch.

There were slow changes in this policy: the 50% of the entrants to MBBS program were from I. Sc stream. Ultimately, the practice of enrolling students from among the middle level health workers was discontinued in 2000. There were changes in training of middle level health workers and their employment opportunities too. Some of the unfounded criticism against enrolling students from midlevel health workers was their inadequate exposure to basic science subjects such as biology, chemistry and physics. These subjects were taught to mid-level health workers too. I don't remember any scientific study to prove this conjecture.

The reasons for moving to some different criteria for admission to MBBS program are many: the original arrangement assumed that all the graduates of Middle Level Health Worker program (HA, Staff nurse, pharmacists, lab technicians etc) would immediately be employed with the government and would have opportunities to complete the required duration of compulsory service before applying for the MBBS program. However, yearly recruitment by the government didn't match this expectation. In addition, there was apparently resistance from the society (well educated persons, doctors, bureaucrats etc. who were aware of the practices in other countries) were probably pushing for opening it to those who complete 12 years of secondary education with science background. Multiple factors must have played the role, I was not directly involved in the process, and my guess would be as good as any.

However, the curricular innovations of integrated basic science curriculum, early clinical exposure and community orientation were continued. However, the increasing number of institutes of health sciences and private medical colleges has created problems in identifying communities for student placements. The rapid increase in medical colleges established in the private sector had to depend on faculty from India who probably had not much exposure or commitment to the teaching-learning activities required by such a community-oriented and based curriculum. There might have been exposure fatigue on the part of communities too. The change in the enrollment policy (young students who had no exposure to rural living) might also have posed a difficulty. These are my conjectures as I am out of the academic field for more than a decade.

I consider myself very fortunate that, though there were instances of unrest (I was campus chief from 1999 to 2002 and dean from 2002 to 2007) of serving in an administrative position for about 8 years. However, I was a member of a very cohesive team with a common agenda. We worked as a member of the team with different roles and tried to respect each other's territory. I would like to remember the dedication and hard work of my colleagues in the team, especially Dr. Mahesh Khakurel, Director of TUTH, Dr. Trilok Pati Thapa, Assistant Dean, Academic and Dr. Dev Narayan Shah, Campus Chief of Maharajgunj Medical Campus. There were many more with whom I worked but and would like to remember them but can't remember their names after so many years.

We'd a very close relationship with junior staff too. I was on a very open relationship with my junior staff who came forward to tell if they came across any information regarding students or faculty dissatisfaction with something and were likely to present with a problem. I remember being greeted by security guards and support staff as soon as I reached the campus then they would tell me what is being discussed in the hostel or hospital which is likely to cause problem. I used to alert the concerned official (Assistant Dean Director or Campus Chief, Hospital director), which helped us to take a proactive approach which prevented escalation of the issue.

I used to advise our students to work with maturity when dealing with any problem: maturity meant ability to clearly state the problem and what they wanted as a solution but at the same time understand the viewpoint or the situation of the administration or other party as well. We'd our share of conflicts but none of them were beyond reaching amicable solution.

The relation between faculty and students also used to be very open and I used to address my MBBS students by their names, this practice of mine is remembered even today when I meet with my former students (now senior faculty or retired officials). I learned the benefits of this approach from my professor of Pediatrics at Darbhanga Medical College and faculty of AIIMS pediatrics department.

Academic administration was a new subject for me and my colleagues. We took it as a challenge but with a humility, owning that we didn't know everything and and we need to work with others. We'd respect for the education, training and experience of others, and we didn't hesitate to ask. Higher up officials did not interfere with us. TU fully supported our work. These might have been some of the factors that might have helped.

Q7. As an expert in nutrition and author of Child Nutrition and Health, how do you assess the trends in the nutritional status of Nepali children over the past four decades? What community-based interventions do you consider most crucial for improving child and population health in Nepal?

Answer: Thank you for bringing attention to the field of nutrition. When I started working in the field, the nutritional status of Nepalese children was dismal. The Nutrition Status Survey of 1975 found that more than half of Nepalese children under five years of age were stunted. Night blindness, iodine deficiency, and nutritional anemia were other major child health problems. Government programs at the time focused mainly on child survival through the prevention of diarrheal deaths. Poor antenatal services, inadequate childcare, improper feeding practices, poor hygiene, and lack of sanitation were all identified as determinants of this situation. The main causes of child mortality were listed as diarrheal diseases, pneumonia, and malnutrition. Infectious diseases such as diphtheria, tetanus, and measles were also common causes of death.

Child survival strategies therefore promoted growth monitoring, oral rehydration, breastfeeding, immunization, family planning, food supplementation, and female education, all aimed at addressing the common determinants of child health. Nutrition programs attempted to develop a coordinated approach through joint nutrition support initiatives that included health, education, agriculture, and poverty reduction measures (such as home gardening and female employment). The current Multi-Sector Nutrition Plan of Action, endorsed by the National Planning Commission, is a continuation of those earlier initiatives.

The situation has improved significantly, and the reasons are many: a reduction in the proportion of the population below the poverty line, improved water supply and sanitation, expansion and coverage of immunization, better infrastructure, and decentralization in governance. Some child health programs with particularly significant impact include the national Vitamin A supplementation program, the integrated management of neonatal and child illnesses, the training of Female Community Health Volunteers to implement the IMNCI program in communities, the expansion of antenatal care services, and the promotion of facility-based deliveries. These represent important milestones in Nepal's journey toward improving child health and nutrition.

Q8. You served as Coordinator of the Ethical Review Board of the Nepal Health Research Council (2000–2014) and later as Chairperson (2021–2024). How

would you describe the evolution of ethical review and research governance in Nepal, and what key areas still require strengthening?

Answer: I am very happy to have been involved in the activities of the Nepal Health Research Council (NHRC) since its earliest days. In 1995, I was asked to review research proposals, though I had no formal training in the subject and had to search for materials to carry out the assignment to the best of my ability. I developed a checklist for the review, which was later incorporated by Dr. Mathura Prasad Shrestha when he authored a guideline for reviewing research proposals. After a few years, I was entrusted with the responsibility of reviewing proposals for their ethical aspects.

In the early years, NHRC had formed two subcommittees: one for technical review and another for ethical review. This practice continued until 2001. Dr. Gopal Prasad Acharya joined NHRC as Chairman in 2000 and mobilized resources to organize consultation meetings for the formulation of National Ethical Guidelines for research in Nepal. International experts in health research and ethics were invited to contribute to the consultation. This process raised awareness among national researchers about the importance of ethics in research and the procedures required to ensure ethical conduct in studies involving human participants. The first National Ethical Guideline, published in 2001, was the outcome of these consultations and deliberations. Following its endorsement, an independent Ethical Review Board (ERB) was established in 2001, combining both technical and ethical subcommittees. I was appointed Coordinator (acting as Chair) of the board, a position I served in for 14 years.

The progress made in enabling researchers to consider ethical aspects of research, while promoting the dignity and interests of participants, was significant. NHRC developed various guidelines on topics such as animal experimentation, pharmaceutical research, and the formation of institutional review committees. These guidelines continued to be reviewed and revised over time.

After a hiatus of about five years, I rejoined the ERB in 2019 as a member. The terminology of "Coordinator" was changed to "Chair" to align with international practice, where Ethical Review Committees are headed by a Chair. It was gratifying that immediately after my return, the ERB underwent an assessment of its functioning by the Forum for Ethical Review Committees in Asia and the Pacific (FERCAP) in 2019 and received accreditation in recognition of its alignment with international standards for reviewing, approving, and monitoring health research in Nepal. FERCAP is a forum established to protect the interests of participants in health research through oversight, education, and training of researchers, reviewers, and committee members.

I was honored to be asked to chair the ERB again from 2021 to 2024. During this period, NHRC successfully hosted the annual FERCAP conference in 2024.

Over the years, NHRC's capacity for timely review and approval has improved tremendously. However, challenges remain. The ERB secretariat still requires nurturing with full-time, committed research staff. Retaining trained human resources and effectively monitoring research projects continue to pose challenges. The secretariat must also contend with non-cooperation and, at times, refusal by researchers to comply with ERB recommendations or instructions. Nevertheless, the recent digital linkage of all Institutional Review Committees (IRCs) with the ERB is a welcome development that promises better management.

The capacity of academia and institutions to review and conduct research has increased, but monitoring within these institutions is often hampered by limited cooperation from researchers and inadequate resources at the IRC level. These issues demand continuous vigilance. Institutional support must be strengthened to ensure this aspect of health research.

Adequate training and education of faculty members is another pressing issue that university administrations need to address. Too often, research proposals from students are submitted to IRCs and the ERB without sufficient scrutiny by faculty. As a result, IRC members are forced to deal with problems that could have been resolved at the departmental level. This not only strains committee resources but also wastes valuable time and effort that students could have better utilized.

Q9. There is an ongoing debate regarding the dual role of the Nepal Health Research Council as both a regulatory body for research ethics and an institution conducting research. Additionally, concerns have been raised about inclusivity in leadership, particularly the predominance of medical professionals. How do you view these debates, and what reforms would you suggest?

Answer: Thank you for raising the issue of membership within the NHRC executive committee being dominated by medical professionals. This arrangement needs to be reviewed and revised to make it more inclusive. The areas of research and the types of studies being carried out have diversified tremendously, and this should be reflected in the composition of the NHRC executive council.

Regarding the issue of NHRC conducting research on its own, I would like to emphasize that NHRC is not

only a regulatory authority; it is also an important resource for conducting research on topics of national importance, relevant to health, and for creating a knowledge base to guide policymakers. There may be important health issues that do not receive sufficient attention from academia or industry, and in such cases, NHRC may need to step in.

Q10. As a former member of the Medical Education Commission (MEC) of Nepal, how do you assess 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?

Answer: I was a member of the committee formed under the chairmanship of Kedar Bhakta Mathema, former Vice-Chancellor of Tribhuvan University, to review the challenges in medical education and suggest a way forward. The issues under consideration included multiple entrance examinations and the lack of transparency in the fee structures of various private medical colleges.

Later, I served as a member of a committee tasked with reviewing the achievements, progress, and reforms needed after three and a half years of the formation of the Medical Education Commission (MEC). The committee noted that MEC, established following the recommendations of the Mathema Commission, had achieved success in introducing a central entrance examination and regularizing fee structures. However, the review committee also observed that the Act required revision to address ongoing challenges and that administrative strengthening was overdue.

The system of appointing a Vice-Chairman and divisional directors every four years, with a secretariat staffed mainly by administrative personnel, was inadequate for carrying out responsibilities effectively. A strong support infrastructure, including knowledge resources, needs to be established. I believe that a group of experts in medical education, accreditation, assessment tools, and digital applications for monitoring student learning should be a permanent part of the MEC team. At present, MEC relies heavily on external experts, whose continuity and quality of contribution cannot be assured.

In addition, MEC should have adequate resources to conduct educational research, thereby enhancing its ability to guide and collaborate with universities and academies in the field.

Q11. The Government of Nepal is in the process of introducing an Umbrella Act for Health Sciences Academies. In your opinion, what opportunities and challenges might this legislation present for health sciences education and governance in Nepal?

Answer: I am not familiar with the proposed Act; therefore, I cannot offer a studied opinion. However, I once chaired a government-appointed committee tasked with examining whether the creation of a centralized university to oversee health professionals' education would improve quality. Our deliberations and resulting recommendations favored allowing different academies and universities to retain academic freedom and pursue diverse approaches to education. Challenges such as poor governance or conflicting interests cannot be resolved simply by centralizing the process. I believe the academic field should remain open to innovation and experimentation with different approaches.

Centralizing academic administration could help prevent duplication in entrance examinations, faculty requirements, and training opportunities. However, it also carries the risk of enforcing a uniform path which, if misguided, could lead to serious consequences. Thus, caution is necessary, and space must be left open for the flourishing of diverse ideas and approaches.

Q12. You served as Chief Editor of the Journal of the Nepal Medical Association (1987–1989) and the Journal of the Institute of Medicine (1992–1994). How do you assess the current quality and volume of biomedical research publications in Nepal? What steps are needed to improve research quality, research culture, and scholarly publishing in the country?

Answer: The progress in the number and quality of scientific publications in the country reflects changes in the field of health professionals' education, the expansion and specialization of health care services, and the rapid increase in the number of medical colleges, academies, and universities. This development can be divided into preliminary stages, a growing period, and the current stage, where the need for publications to advance academically has created a strong demand for opportunities to publish among aspiring professionals.

I consider the period when I served as editor to represent the middle stage of development. At that time, editors did not need to solicit articles, but the quality of submissions was not assured. It was difficult to find qualified reviewers, and authors often lacked the inclination to revise their manuscripts according to reviewers' suggestions. The editorial team had to actively facilitate this process.

We have come a long way since then. Submissions to journals are steadily increasing, most journals now have robust review systems, and prospective writers are gaining opportunities to learn how to prepare articles after completing their research. The teams working at the Journal of the Medical Association of Nepal, Kathmandu University Medical Journal, and

the Journal of the Nepal Health Research Council are playing key roles in strengthening scientific publishing. I am confident that JPAHS is also contributing to this endeavor.

The initiative taken by the Nepal Medical Association to provide training opportunities in scientific writing and publication is a welcome development that should be replicated by other institutions that publish journals. However, the current tendency for every medical college to publish its own journal, primarily to support in-house faculty members in their academic advancement, needs scrutiny. It is essential to ensure that such publications undergo rigorous peer review processes to maintain quality and credibility.

Q. 13 Many people have contributed to the advancement of medical education and research ethics in Nepal. However, the new generation is often unaware of this history and the contributions made. Could you share some names and highlight their roles in shaping medical education and research ethics in Nepal through their innovation and commitment?

Answer: Dr. Moin Shah, the first Dean of the Institute of Medicine, provided the initial leadership to establish community-oriented medical education in Nepal, despite prevailing resistance and opposition from the medical community. He was fully supported by the government and his team, which included Dr. Hemang Dixit, Dr. Bhishma Raj Prasai, and Dr. Mathura Prasad Shrestha. Dr. Narendra Rana and Dr. Dambar Bahadur Karki also played key roles in helping the Institute of Medicine initiate postgraduate programs through collaborative partnerships among valley hospitals. Dr. Upendra Devkota must be credited for the creation of the National Academy of Medical Sciences.

Mr. Girija Prasad Koirala was pivotal in mobilizing support from the Indian government to establish the BP Koirala Institute of Health Sciences, with Dr. Madan Prasad Upadhyay and Dr. Shekhar Koirala instrumental in its early development.

Dr. Ram Prasad Pokhrel should be remembered for his contribution to expanding eye health services nationwide, making it an area of pride for Nepal by serving patients from neighboring countries. The work of Dr. Sanduk Ruit and the Tilganga Eye Institute builds upon the foundation laid by Dr. Pokhrel.

Dr. Arun Sayami played a central role in establishing the Shahid Gangalal Heart Center in Bansbari, while the relentless efforts of Dr. Bhagwan Koirala deserve credit for the services now available at the center. Dr. Sayami also mobilized government resources to establish the Manmohan Cardiothoracic and Vascular Service Center within TUTH. Similarly, Dr. Madan Upadhyay and the BP Eye Foundation must be acknowledged for establishing the BPK Lions Center for Ophthalmic Services. Dr. Arjun Karki took the initiative to establish Kathmandu University Medical School and later mobilized political support to create the Patan Academy of Health Sciences.

Since 1991, there has been commendable expansion in medical services, with an entire generation of professionals contributing in diverse ways. The list of contributors is long, and inevitably some important names don't appear in this list.

Beyond the academic field, several individuals also deserve recognition. Dr. Narayan Keshari Shah was the first to work with Robert Worth to produce the Nepal Health Survey (1965–66). Dr. Mrigendra Raj Pandey pioneered research on smoking-related exposure and chronic obstructive lung diseases. His studies on acute respiratory infections in children contributed to the development of national control and prevention programs. Dr. Pandey was also instrumental in establishing the Nepal Health Research Council.

Dr. Madan Prasad Upadhyay is credited with identifying Seasonal Hyperacute Panuveitis, a condition causing blindness in children exposed to white moths.

Dr. Dharma Sharna Manandhar and the MIRA group are recognized for their work on the role of mothers' groups in improving maternal and neonatal health.

Dr. Buddha Basnyat is noted for his pioneering work on acute mountain sickness. He mobilized resources to train physicians in mountain medicine and later contributed to improving treatment for typhoid fever and the development of an effective and safe vaccine.

All health professionals who dedicated themselves to patient care, identified problems in the process, mobilized resources, and carried out research to find solutions deserve recognition. Here, I have listed some prominent names, though others may have been missed inadvertently.

Q14. You have provided long-standing social, emotional, and financial support to various institutions, including the establishment of the "Dr. Neelam Adhikari Memorial Research Fund" at PAHS through a generous endowment (NRs. 10 million) in memory of your late wife, Prof. Dr. Neelam Adhikari. What message would you like to share with future leaders, faculty, and students of PAHS to help sustain its mission and enhance its national and global impact on teaching, service and research?

Answer: Thank you for giving me the opportunity to share my views on how senior professionals can support the newer generation. I strongly believe that those with resources should make them available for the benefit of posterity, advancing both learning and health care.

I am grateful to the leadership of the Patan Academy of Health Sciences (PAHS) for transforming my modest financial contribution into a fund established in memory of Dr. Neelam Adhikari. She served Patan Hospital for more than 30 years and continued to be engaged in postgraduate education even after retirement. She conducted weekly clinical classes for pediatric residents, which were discontinued only after she was diagnosed with an incurable illness and during the shutdown caused by the COVID-19 epidemic. Many of the currently practicing faculty and pediatricians still speak fondly of her classes.

The initiative of PAHS leadership is commendable, as they considered it an appropriate use of the fund to promote research among students and faculty members. I hope that this example will inspire more such initiatives in the future.