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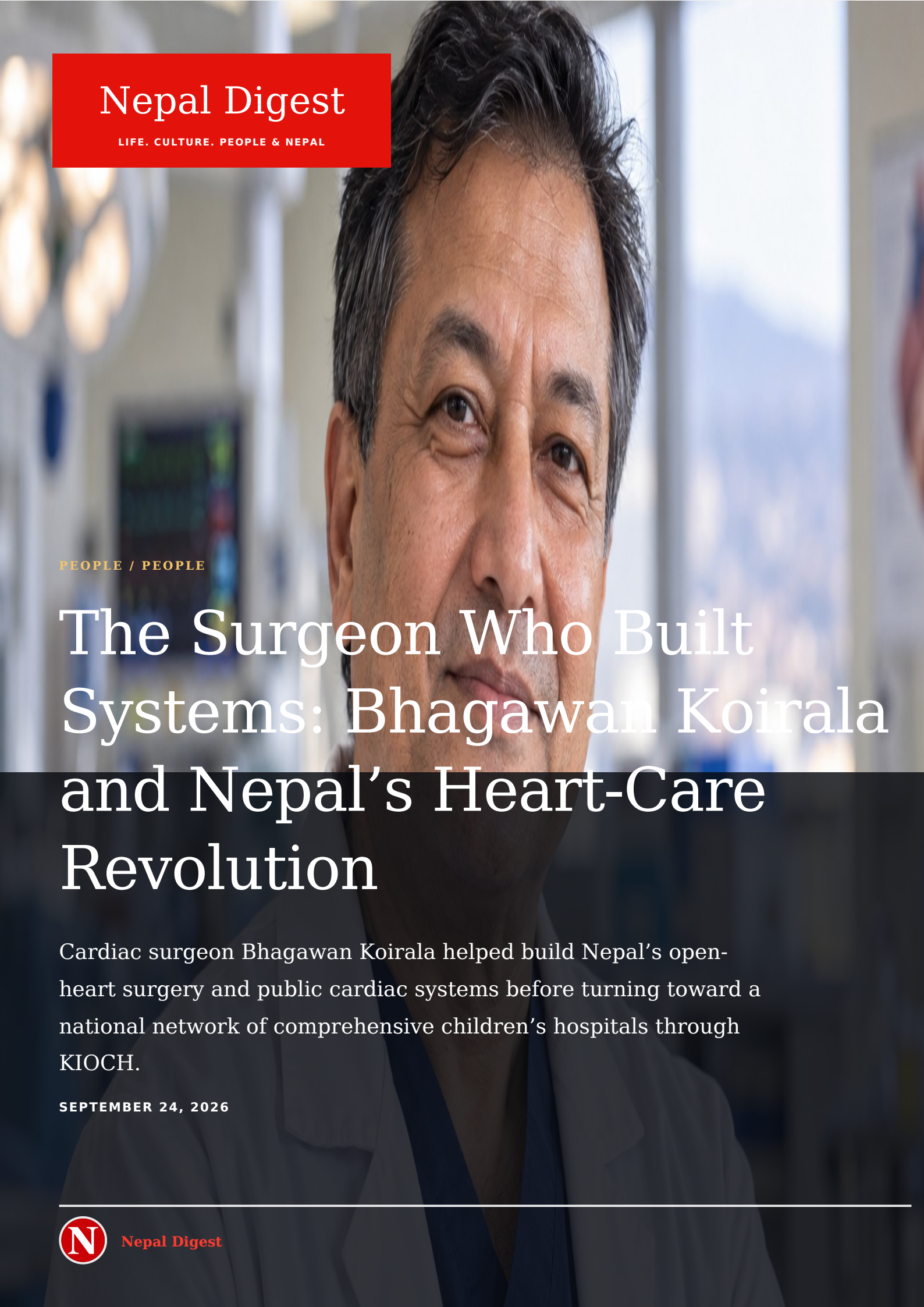

PEOPLE / PEOPLE

The Surgeon Who Built Systems: Bhagawan Koirala and Nepal’s Heart-Care Revolution

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The Surgeon Who Built Systems: Bhagawan Koirala and Nepal’s Heart-Care Revolution

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Bhagawan Koirala is best known as a heart surgeon, but the larger story of his career is about something more difficult than surgery: building institutions that continue working when one talented doctor is not in the room. He helped establish open-heart surgery in Nepal, led major public cardiac centres, trained teams and repeatedly stepped into hospital-management roles where clinical skill alone was not enough. In the later phase of his career, that same systems mindset has been directed toward a national

network of children’s hospitals through the Kathmandu Institute of Child Health.

The distinction matters because medicine often celebrates individuals. A surgeon performs a difficult operation, a patient survives and the doctor becomes the story. Yet advanced healthcare is never created by one person. It depends on anaesthesia, nursing, laboratories, intensive care, blood banks, procurement, administration, maintenance, referral systems and hundreds of people whose names rarely appear in public profiles.

Koirala’s career repeatedly moved from the dramatic part of medicine into this less visible machinery. That is what makes his contribution significant. He did not simply prove that complex heart surgery could be performed in Nepal. He spent decades asking whether public hospitals could perform it reliably, affordably and at scale.

From Palpa to Medicine

Koirala was born in Palpa and entered medical training unusually young. In an early Nepali Times profile, he recalled passing the School Leaving Certificate at thirteen and enrolling in a health-assistant programme at the Institute of Medicine after his family adjusted his official age to make registration possible.

The story reveals both his academic ability and the unusual path by which many Nepali doctors of his generation entered medicine.

The country’s health system was still developing, and professional routes were less standardised than they are today.

His early exposure to clinical work eventually led him toward full medical education and then advanced surgical training abroad.

Training Across Several Countries

Koirala’s medical education took him through Nepal and international institutions in Ukraine, Bangladesh, the United States and Canada. He ultimately specialised in cardiothoracic surgery and received additional training in paediatric cardiac surgery.

For Nepali doctors, advanced training abroad often creates a difficult choice. The best equipment, salaries, research facilities and professional support may be available outside the country. Returning can mean accepting greater institutional frustration and fewer resources.

Koirala returned anyway, placing himself inside a system that still had to build much of the infrastructure his specialty required.

Why Cardiac Surgery Requires a System

Open-heart surgery is an ideal example of why medicine cannot be reduced to individual talent. The surgeon cannot operate safely without a perfusionist managing the heart-lung machine, an

anaesthesia team controlling physiology, nurses maintaining sterile technique and an intensive-care unit capable of supporting the patient afterward.

Imaging, laboratory services, blood products and reliable equipment maintenance are equally important. A failure in any one layer can compromise the entire procedure.

Building cardiac surgery in Nepal therefore required creating a multidisciplinary institution, not simply training one surgeon.

Shahid Gangalal National Heart Centre

Koirala became closely associated with Shahid Gangalal National Heart Centre in Kathmandu, where he helped develop modern cardiac services and establish public confidence in advanced heart treatment inside Nepal. The centre became one of the country’s most important specialised public hospitals.

In the early years, many Nepali families assumed that complex heart operations required travel to India or farther abroad. Successful surgery at home changed both clinical access and public expectation.

The shift saved families from the financial and logistical burden of medical travel while allowing local teams to build experience through higher case volumes.

Pioneering Open-Heart Surgery

Koirala is widely recognised as one of the pioneers of open-heart surgery in Nepal. The phrase can sound heroic, but the achievement becomes more meaningful when understood institutionally.

The first successful procedures demonstrate possibility. The hundredth procedure demonstrates reliability. A mature programme is one in which patients are treated successfully even when the founding surgeon is not personally managing every decision.

Koirala’s work therefore had to move quickly from proof of concept toward team-building.

Public Medicine as a Choice

Koirala remained strongly associated with public hospitals despite opportunities for a more commercially comfortable career. This choice contributed significantly to his public reputation because specialised cardiac care can be financially catastrophic for households.

Public medicine is harder than private practice in one important respect: demand is effectively unlimited while resources are not. A hospital must treat large numbers of people, many of whom cannot pay the true cost of complex surgery.

Clinical quality therefore becomes inseparable from public financing, cross-subsidy and efficient management.

The Management Problem

Koirala developed a reputation as a hospital administrator as much as a surgeon. Nepal’s public hospitals frequently struggle with procurement delays, overcrowding, staff shortages, political interference and weak accountability. None of these problems can be solved with better surgical technique.

He repeatedly argued through practice that management is part of healthcare. If an operating theatre cannot obtain supplies, if a machine remains broken or if a patient spends days navigating referrals, the medical outcome has already been influenced.

This insight pulled him increasingly toward leadership roles in which the patient in front of him was no longer the only unit of concern.

Manmohan Cardiothoracic Vascular and Transplant Center

Koirala also played a major role in the development of the Manmohan Cardiothoracic Vascular and Transplant Center at Tribhuvan University Teaching Hospital. The institution expanded Nepal’s capacity in cardiac and thoracic care while creating another training environment for specialists.

Multiple high-quality centres matter because a national health system should not depend on one hospital. Competition can improve standards, while distributed capacity reduces dangerous bottlenecks.

For Koirala, institution-building increasingly meant creating systems that could replicate expertise rather than concentrate it.

Training the Next Team

One of the least visible contributions of senior physicians is training. A surgeon’s personal case numbers eventually stop; the doctors and nurses trained under that surgeon may work for decades afterward.

Specialised medicine becomes sustainable only when knowledge is transferred deliberately. Nepal cannot rely indefinitely on sending every future cardiac specialist abroad.

Koirala’s legacy therefore includes a generation of clinicians, technicians and administrators who developed within the programmes he helped build.

The Hero-Doctor Problem

Public trust in individual doctors can be valuable, especially in countries where confidence in institutions is weak. But hero worship can also become dangerous. Patients may believe quality

exists only when one famous doctor is available.

Koirala’s systems approach points toward the opposite goal. The hospital should become trustworthy enough that patients do not need to know which individual is on duty before feeling safe.

The best institution makes its founder less necessary over time.

Health-System Leadership

Koirala’s career expanded into health regulation and broader policy roles, including service as chair of the Nepal Medical Council. These positions exposed him to problems that surgery alone could not solve: professional standards, workforce planning, medical education and accountability.

Regulation is often unpopular because it limits individual freedom, but medicine requires standards precisely because patients cannot independently evaluate every clinician’s competence.

Koirala’s movement between service delivery and regulation gave him a wider view of how clinical quality is produced nationally.

The Workforce Crisis

In recent years, Koirala has spoken increasingly about the migration of Nepali doctors and nurses. Trained professionals leave because compensation, working conditions and career opportunities are often better abroad.

Criticising them morally does not solve the problem. If Nepal wants health workers to remain, hospitals and government must make staying professionally rational.

Koirala has argued for better pay and for stronger enforcement of obligations where publicly supported training includes formal commitments to return.

Why Primary Care Still Matters

It might appear paradoxical for a specialist heart surgeon to emphasise primary healthcare, but the logic is straightforward. Many serious diseases become more difficult and expensive because they are detected late.

High-end hospitals cannot compensate for weak prevention, screening and local care. A health system that invests only in sophisticated urban hospitals will always receive too many patients after avoidable complications have developed.

Koirala has repeatedly argued that specialist capacity and primary care need to grow together.

Children Become the Next Mission

Later in his career, Koirala turned increasing attention toward paediatric healthcare. His own training included children’s cardiac surgery, but the issue extended far beyond heart disease.

Nepal lacked a comprehensive system where children with complicated conditions could receive several kinds of specialised treatment under one institutional roof. Families were often transferred between hospitals because no single centre contained all the services required.

Koirala began working on a new model through the Kathmandu Institute of Child Health, or KIOCH.

The KIOCH Vision

KIOCH was built around an ambitious idea: establish a comprehensive children’s hospital in Kathmandu while developing satellite or provincial hospitals across all seven provinces. The goal was to reduce the need for families to travel repeatedly to the capital for specialised paediatric treatment.

This is a much larger systems problem than building one excellent hospital. A national network requires referral protocols, trained staff, financing, telemedicine, logistics and consistent clinical standards across different locations.

Koirala has repeatedly emphasised that he does not want the project to become a hospital dependent on his personal presence. The institution must outlive the founder.

Why Paediatric Care Is Different

Children are not simply small adults. Medication doses, physiology, communication and disease patterns differ significantly, while family involvement is central to care. A comprehensive paediatric system needs specialists across several disciplines.

Families also experience children’s illness differently. A treatable condition can become catastrophic if diagnosis is delayed because the required specialist is hundreds of kilometres away.

Regional access therefore becomes both a medical and equity issue.

Regional Children’s Hospitals

KIOCH’s provincial model aims to create care closer to families rather than concentrating everything in Kathmandu. The exact mix of services can vary by location, with complicated cases referred into higher-level centres while common paediatric conditions are treated regionally.

This kind of network mirrors how mature health systems organise care: not every hospital performs every procedure, but patients move through a coherent referral chain.

Nepal’s challenge is building the chain in a geography where transport and specialist distribution remain uneven.

The Kathmandu Children’s Hospital

By the mid-2020s, KIOCH’s Kathmandu Children’s Hospital had moved from vision into operation. The institution lists Koirala as chief consultant on an honorary basis while maintaining dedicated medical leadership and specialist teams.

This arrangement itself reflects the systems philosophy. Koirala remains clinically involved but is not presented as the sole operating centre of the organisation.

The hospital’s value will be measured by whether teams function consistently across departments rather than by the presence of one famous surgeon.

Open-Heart Surgery at KIOCH

In 2026, KIOCH announced the successful completion of open-heart surgery at the newly opened Kathmandu Children’s Hospital, performed by Koirala and a multidisciplinary team. The operation represented an important milestone because it connected his earliest professional mission with his later institutional one.

Decades after helping establish cardiac surgery in Nepal, he was again involved in building a programme—this time inside a hospital designed specifically around children.

The symbolism is strong, but the deeper test will be whether such surgeries become routine, accessible and independent of any one surgeon.

Funding a Public-Minded Institution

KIOCH operates in a difficult space between public purpose and non-state institution-building. Specialised paediatric care is expensive, and relying entirely on out-of-pocket payment would contradict the goal of access.

This makes fundraising, philanthropy, partnerships and sustainable financing central to the model. Hospitals require recurring revenue, not only construction donations.

The true financial challenge begins after the building opens.

The Ethics of Access

Advanced medicine raises a difficult question: how much should a society spend on complex treatment when basic services remain weak? The answer cannot be that poor countries should simply avoid specialised care.

Children with treatable cardiac or neurological conditions deserve access because timely treatment can produce decades of healthy life. The issue is how to build specialist systems without starving prevention and primary care.

Koirala’s career increasingly operates inside this balancing problem.

Management as Clinical Care

One of the strongest lessons from Koirala’s work is that hospital management should be considered part of medical quality. Procurement policy affects whether drugs are available. Human-resources policy affects whether nurses are exhausted. Finance affects whether equipment can be maintained.

These decisions may never appear in a medical textbook, but they determine whether textbook medicine can actually be delivered.

Senior clinicians who understand administration are therefore unusually valuable in developing health systems.

Why Reputation Can Be Useful

Koirala’s public reputation has helped mobilise trust, donations and institutional support for projects such as KIOCH. Fame can be a form of capital when people believe the person leading a project will use resources responsibly.

The danger is that institutions become too dependent on that reputation. Once again, the system has to be stronger than the individual who made it possible.

The transition from personal trust to institutional trust may be the hardest stage of KIOCH’s development.

The Next Generation of Health Leaders

Nepal’s future healthcare system will depend on younger physicians who can combine clinical expertise with administration and public responsibility. Medical training often prepares doctors to diagnose disease but not to manage large organisations.

Koirala’s career offers a different model. Clinical excellence created credibility, but institutional leadership multiplied the impact.

The next generation does not need to imitate his exact path, but it can learn that medicine and management are not separate worlds.

The Question of Scale

Koirala’s career began with a technical question: can Nepal safely perform advanced cardiac surgery? The answer became yes. The next questions were larger: can public hospitals deliver it consistently, can teams be trained and can specialised care reach people outside Kathmandu?

Each success revealed a harder problem behind it.

This progression explains why his work moved from operating theatre to institution-building. Scale changes the nature of the challenge.

A Legacy Built in Systems

Bhagawan Koirala will always be associated with heart surgery because the image of a surgeon saving a life is immediate and compelling. But the less dramatic parts of his work may matter more in the long run.

A functioning hospital saves people he will never meet. A trained team performs operations after he has retired. A referral network brings a child to the right specialist without depending on family connections or luck.

The Importance of Clinical Governance

Large hospitals need more than administrators and doctors working in parallel. They need clinical governance: systems for measuring complications, reviewing deaths, standardising protocols and learning from errors. Without this discipline, quality depends too heavily on individual reputation.

Koirala’s institution-building philosophy points naturally toward this model. Surgeons should be able to compare outcomes,

identify preventable problems and adjust systems rather than relying on anecdotal success.

For Nepal, where public trust in institutions can be fragile, transparent clinical standards are especially important. Patients should know that quality is monitored even when they cannot evaluate the technical details themselves.

The Referral-System Challenge

Specialised hospitals work best when patients arrive through organised referral systems. Nepal’s fragmented health network often sends families directly to Kathmandu because local facilities are unsure what they can safely manage.

This creates overcrowding at tertiary centres while regional hospitals remain underused. A better system defines which cases can stay locally and which need transfer, with communication between facilities before the patient travels.

KIOCH’s provincial model will ultimately depend on this coordination. Buildings alone do not create a network; referral behaviour does.

Technology and Telemedicine

Paediatric networks can also use telemedicine to extend specialist expertise beyond the capital. A regional doctor may not need a

paediatric cardiologist physically present if images, laboratory results and clinical findings can be reviewed remotely in time to guide the next step.

Telemedicine cannot replace examination or surgery, but it can reduce unnecessary travel and help local teams decide which patients require urgent transfer.

For Koirala’s systems vision, digital consultation offers one way of multiplying scarce expertise without concentrating every specialist in Kathmandu.

The Institution After the Founder

The hardest test of Koirala’s career may come after he is no longer leading projects personally. Founder-driven hospitals can become unstable when donors, staff and patients associate trust with one individual rather than with governance systems.

Succession planning therefore has to begin early. Boards, clinical leaders, financing models and management culture need enough independence that the institution remains credible without the founder’s daily involvement.

If KIOCH succeeds at that transition, it will validate the central argument running through Koirala’s career: healthcare quality becomes durable only when expertise is converted into institutions.

Medical Education as a Capacity Problem

Nepal’s specialist shortages cannot be solved by building hospitals alone. Every new cardiac or paediatric service requires trained doctors, nurses, technicians and administrators, and those professionals take years to produce. Workforce planning therefore has to begin before new infrastructure opens.

Koirala’s experience makes this constraint unusually visible. A sophisticated operating theatre is useless if no perfusionist is available, and a regional children’s hospital cannot function without paediatric specialists willing to work outside Kathmandu.

Institution-building in medicine is ultimately a human-capital project as much as a construction project.

The Equity Test

Koirala’s public reputation rests partly on the idea that advanced care should not become a privilege available only to wealthy families. This creates the most difficult financial question in his work: who pays for specialised treatment when the patient cannot?

Subsidies, insurance, philanthropy and public financing all have roles, but none is sufficient alone. A hospital committed to access needs a financing model that survives even during periods when donations decline.

The success of KIOCH will therefore depend as much on sustainable financing as on clinical excellence.

What Success Would Look Like

The best outcome for Koirala’s later career would be a network in which parents in distant provinces receive competent paediatric care without first searching for personal connections in Kathmandu. Complicated cases would still travel, but the journey would be organised rather than desperate.

If that system emerges, the achievement will be difficult to photograph. It will appear instead as shorter delays, fewer unnecessary transfers and more children treated early enough for medicine to work.

The final measure is independence. A healthcare system becomes mature when patients can receive excellent care without needing to know which famous doctor is present, which political contact can help or which family member can navigate the bureaucracy. Koirala’s work has increasingly been directed toward that kind of normality.

That is the larger logic of Koirala’s career. The first achievement was proving that complex medicine could be done in Nepal. The harder achievement is building institutions strong enough that it continues to be done well when the famous surgeon is no longer the reason the

system works.

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