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01

Medical Education In Bangladesh

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THE most relevant question being asked by everybody today is whether doctors coming out of our traditional medical colleges, which follow a traditional curriculum, are really competent to serve our community health needs and whether they are attitudinally pepared to serve the community.

The national aim of producing competent general practitoners if compared with institutional objectives of medical education — to produce doctors who will promote health — is not being fulfilled. Should we then continue producing doctors in this traditional way or should we change our policy and strategy of medical education ?

Medical education so far has neither been appropriate nor need based.

To meet our community health needs we should decide what policy, strategy and principles medical colleges should follow and what our priorities should be.

If professional competence is a priority for our future doctors, to make them more responsive towards the health needs of society should we not set the objectives for it ?

Changing medical education is a modern trend. Tremendous development is happening in educational science with much innovation in medical education. It is no more a national or regional issue but a global one. Changes have happened even in our neighbouring countries India and Nepal. The previous traditional medical curriculm in those countries which put more emphasis on memorisation rather than learning has been changed. The teaching learning concept has also changed with more stress on self-directed learning and on developing skills through practice. The curriculum now is more specific and task based. Students are to follow a curriculum with increased vocational and practice-oriented components in medical which helps them to be problems solving doctors.

WHO is promoting Re-orientation of Medical Education (ROME) since seventies. Back in fifties it was felt that the medical education, which is teacher centered, discipline-biased and urban institution-based, needs to be shifted towards actual situation. Therefore in sixties and seventies community medicine departments were established and WHO established a network of regional and national teacher training centres, introducing principles of educational science. With the assistance of UNDP a National Centre for Medical Education (CMED) in Dhaka came into existence in late seventies. A national curriculum was later developed which we claim to be a community — oriented competency based curriculum. A UNDP/WHO report however says it is neither community-oriented nor competence based. So there is a need to review the existing curriculum and to bring need based changes in it.

WHO organized a series of meetings and consultations with analysis of country situations and set some targets to bring improvements. The targets included :

a) Developing a medical education system responsive and relevant to the country need in terms of quality and quantity of doctors.

b) Re-orienting the existing curriculum with the active cooperation of medical teachers and other relevant people.

c) Carrying out education programme reform by adopting proper criteria and procedure for selection of medical students and their performance after being graduates.

d) Bringing curriculum changes with modification of the student assessment procedure.

As mentioned, changes in medical education with innovative concepts have already happened in institutes of neighbouring countries in South-East Asia and other regions in the past decade. They were successful in formulating the goal for ROME which envisages that by the year 2000, all medical schools should be producing graduate or specialist doctors who are responsive to social and societal needs and who will possess the appropriate ethical, social, technical, scientific and management abilities in comprehensive health systems based on primary health care.

A series of general targets has been identified by the countries of this region including Bangladesh keeping specific targets according to individual countries Aga Khan University in Pakistan, Christian Medical College in Vellore, PGMIR in Chandigarh, AIIMS in the New Delhi, JIPMER in Pundichery, India, Peradunya University Medical Faculty in Sri Lanka, and Medical Institutes in Nepal can be mentioned as leading institutes in bringing changes. The changes included reorientation of undergraduate and postgraduate medical education system, putting more emphasis on community based teaching. They introduced problem-based and self-directed learning and integrated teaching in their institutes.

Now, if we come back to our situation, did we formulate a goal for ROME ? Does it identify what type and what number of doctors we shall be producing by the year 2000 ? Will they be responsive to our social and societal needs ?

Did we take a strategy to train them as required ?

We are yet to have a national health policy and medical education policy. We should set a strategy for that set the priorities and make an action plan for that.

Sporadic developments are happening in our health sector. But until and unless we have a medical education policy and make an assessment of our health manpower needs we cannot achieve what is targeted as proper health care service.

We now have about 24,000 registered doctors, about 9000 of them in government services and about 15,000 are self-employed or working with NGOs.

We have about 20 medical colleges now and more medical colleges are coming into existence. We are producing about 1,500 basic doctors every year. Very few of them will be absorbed in government services, but most of them will be absorbed by the community. These doctors should be competent to serve the community health needs. So the institutes much adapt a curriculum which reflects the community health needs.

We should accept the concept of producing "five star" doctors who will have five principles.

a) As care givers besides individual treatment they will also offer a full range of curative, preventive and rehabilitating treatment of the highest quality.

b) As decision markers they are to take appropriate decision on efficacy and cost effectiveness of treatment.

c) As communicators they must acquire an excellent communication skill to persuade individuals families and communities to bring a positive attitudinal change to adopt healthy life style and to promote health to others.

d) As community leaders they should play a role outside their medical task to work in the community to identify community health risks and lead the community to be a partner in eradication of those factors in collaboration or cooperation with other agencies.

e) As Managers they should acquire managerial skill to work as a health team in exchanging views and information and to work together in association with other partners in health, economical and social development.

If medical educationists in this country can accept the concept of 'Five Star Doctor's Principle, they should play their role in motivating our policy makers and planners. They should then sit together to formulate and develop a medical curriculum which will equip our doctors with the necessary knoweldge, skill and attitude to cater to our health needs to the satisfaction of our people.

The other steps should be the need assessment of our medical manpower and re-organization of our existing medical education system by strengthening the Directorate of Medical Education, empowering them with decision-making authority.

A health policy for all with medical education policy is a long felt need for this nation and a pre-requisite to have a proper health care system. The sooner the policy makers and planners realise it the better for the country. (Acknowledgement : Dr Charles Bowen, Prof Myo Thwe of WHO).

The author is a medical educationist and is working with a project for improvement in medical education.