Undergraduate medical education (Bachelor of Medicine and Bachelor of Surgery – MBBS) started in the land of Bangladesh in 1948 with the establishment of Dhaka Medical College in response to be partition of British India to accommodate students returning from Kolkata Medical Colleges and others remaining in the territory of India. From 1948 till the independence of Bangladesh in 1971, eight government medical colleges were established in different years, though Sir Salimullah Medical College was offering short (MBBS) courses to LMF holders only. Soon after the independence in 1972 Sir Salimullah Medical College stopped courses for LMF and started enrolling fresh students like other 7 government medical colleges. The first non-government medical college was established in 1985. Then gradually new medical colleges kept on adding both in the government and non-government.

Bangladesh is committed for improving quality of medical education along with modernization and revising as per need of the country (GOB 2012, GED 2012). However, there was questions of standardization and unhappiness with the quality and management of non-governmental medical education (GOB 2012). The unplanned establishment of huge numbers of medical colleges both in public and private sectors with limited resources in unexpected limited time with gross shortage of qualified faculties creates a big hue and cry in the medical education of Bangladesh.

The non-clinical subjects and other supportive environment for effective knowledge and skill development (GED 2015, MOHFW 2015a, HRMU 2016) faces critical crisis with 111 total medical colleges of variable standard. Professional regulatory bodies are found to have inadequate capacities to enforce standards or quality among the professionals they represent (GED 2015). The accreditation through national accreditation body, Quality, standardization issues remain major challenges (MOHFW 2015a). There is lack of highest level of regulatory council in medical education also.

There is defective planning of the Curriculum (ignoring the importance of demographic, cultural and socio-economic realities of the country and lack of expertise in key stakeholders); defective admission policy, Curriculum contents lacks update and relevance, ineffective instructional methods, inadequate clinical training, poor objective assessment system, poorly designed Internship training programme, lack of teaching staff and resources, huge and unplanned establishment of new medical colleges and lack of community-based training.

The integrated competency based curriculum established in many developed and other developing like India, Srilanka, Nepal etc is now focusing new competency module on ethics, behavior science and constructed communication skill for all medical graduate and medical teachers are trained to cop up the new competency. To acquire the SDG, the medical education and service need to updated quickly as the SDG section 4 aims to give universal health and education coverage with quality education within year 2030. The best practiced in existing curriculum should be accompanied by new development of competency based curriculum development for every country including Bangladesh. Although neighboring countries took steps for time oriented changes, there has been lack of initiative of such novel approach in Bangladesh. These changes in a country need prior processed evidence generated to formulate the ideas.

Current medical curriculum for MBBS need to be updated keeping understanding the gaps in teaching methods and formulating ideas to resolve the gaps. Here are few novel ideas which can be incorporated in undergraduate curriculum 2012.

1. Regarding admission test: question set is weak comprising poor standard of questions. The students are getting chance officially despite poor quality in english resulting in difficulty for them in following lectures. To judge English proficiency, more number for English can be allocated in admission test. Alternatively, English course may
be initiated before getting started classes. Foreign
students should be evaluated by entry test before
admission. There should be search the cause why
English medium students are lagging behind with
good English proficiency. Attitude, behavior of
students should be assessed before entry.

2. 11 steps of integrated teaching need to be
implemented practically. Steps should be redefined
whether it can be done horizontally, vertically or
spirally. It was introduced unwisely in 2012
curriculum without knowing in-depth of it and
analyzing the present situation. Current teaching
staff is not sufficient enough to support integrated
teaching. Modules can be developed in favor of
integrated teaching. Step by step introduction of
this important methods needs to establish.

Though Malaysia and western world are practicing
the integrated teaching fully but our neighboring
country India is struggling to implement it
successfully. Moreover, support from government
and policy maker is important.

3. Pathology and pharmacology need to be taught in
phase II of curriculum as students now have a
vacant state in ward experience without having any
knowledge on these two important subjects for
clinical correlation. In case of forensic medicine,
the topics needed to know is injury and medico
legal aspects of it and forensic pathology can be
merged with pathology. The poisoning cases need
to be addressed in clinical medicine and only the
fatal cases need forensic pathology.

4. There should not be carry on system after failure
of 1st professional exam. Reduction of number of
in course assessment examination like term final
should take into consideration. Supplementary
examination should be taken in a fixed center.
Merging of students of curriculum 2002 with
curriculum 2012 needed to be thought of.

5. Faculty development course needs to be executed
properly. Subject committee and Phase committee
meeting need to carry out regularly.

6. Group discussion is encouraged to prepare a good
lectures and microteaching. Little group discussions
are also encouraged to help students to overcome
difficult topic. Learning difficulty of students and
teaching difficulty of teachers should be rectified.

7. Monitoring should be done by CME. To implement
effective monitoring method in our country, digital
visit can be introduced instead of field visit.

8. The number of students for bedside teaching or
small group teaching should not exceed 15

9. A post graduate degree holder should get a registrar
post to ensure quality teaching.

10. Bed side teaching and patient exposure is
mandatory. OPD placement has to be compulsory.

Subject committee should supervise it. The main
responsibility goes to the Principal of a medical
college or academic Co-ordinator.

The medical education around globe is changing with
updated methods which are important to create an
efficient community oriented empathic altruistic
physician. The paradigm of medical education is shifted
from teacher's oriented knowledge based to integrated
competency based education. Developed countries
already adopted the changes of graduate curriculum
into action while the developing countries are on the
process of change.

Therefore, on the basis of needs, it is demanding to
accommodate the new knowledge in medical education
curriculum to consider the primary health care in the
community and involving in scientific research on our
own health issues. It is now well-established that
health care services cannot be improved unless the
defective educational process of the medical education,
which produces the physicians and other health
personnel changes dramatically. Medical education is
practical and dynamic discipline and those need
constant review and research to become as well as to
remain a useful tool to the society.

Md Robed Amin¹, Quazi Tarikul Islam²

¹Associate Professor of Medicine, Dhaka Medical College,
²Professor of Medicine, Popular Medical College

References:

Health in Bangladesh 2007: Health Workforce in
Bangladesh, Who Constitutes the Healthcare System?
Dhaka. James P. Grant School of Public Health, BRAC
University

Health Policy 2011. Dhaka

Plan of Bangladesh 2010-2021: Making Vision 2021 A
Reality. Dhaka. GED, Planning Commission

Year Plan FY2016-FY2020: Accelerating Growth,
Empowering Citizens. Dhaka. Planning Commission

gov.bd

HRMU, MOHFW

Strategic Investment Plan (HNPSIP) July 2016–June
2021: Better Health for a Prosperous Society (Draft 2.1).
Dhaka