Teachers Views on Teachers Evaluation in Medical Colleges of Bangladesh

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Abstract

Teacher evaluation (TE) is systematic, periodic evaluation of a teacher with respect to his/her performance on job and his/her potential for development. This descriptive type of cross sectional study was conducted from July/22 to June/23 at four governments and four non-government medical colleges selected conveniently, to explore the views of the teachers regarding TE, sources of TE, merits and demerits of different sources, challenges and suggestion to overcome challenges to implement TE in medical colleges of Bangladesh. A total of 227 conveniently selected medical teachers were enrolled. Data were collected through a self-administered semi-structured questionnaire from teachers. Study revealed that majority of the teachers (89.4%) were in favor of TE, around 52% teachers agreed TE may be done once in a year. Areas to be evaluated are teacher's teaching performance and depth of knowledge with a number of other areas. Sources of information, in order of preferences are student, trained evaluator, senior teacher, self and peer. Challenges of TE are training of the evaluator (86%), motivation of the teachers (82%), creation of unhealthy competition among the teachers (63%) etc. Study suggested for collaboration between medical educationist, teachers and policymakers (84%); inclusion of TE in faculty development program (83%), formulation of a legal frame (81%), introduction of a standard evaluation tool by DGME (82%) and may be started initially as a pilot program (80%). Study concluded and recommended that TE should be initiated and may be once a year. Areas to be evaluated are teaching skill, class room performance, depth of knowledge, unbiased assessment, research work, publication and other parameters. Sources may students, trained evaluator, senior teachers, self and peer. Proper guidelines should be developed for TE by the respective authority. Standard evaluation tools should be developed and TE may be linked with faculty development program.

Keywords: Teacher evaluation, Medical education, Bangladesh.

Introduction:

The responsibility of the medical teacher is to train the medical students in such a way that they become a productive member of the health care workforce and are competent enough to improve the health indices of the general population.[1] The quality of teaching learning process at medical college depends mainly on infrastructure that includes competent personnel, optimal teaching space and equipment in accordance with existing standards and norms. Faculty hence remains the cornerstone of overall academic performance of the institution.

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Teachers evaluation and faculty development training strengthens, further academic excellence.[2]

In the last few decades, the significance of teaching evolution has been emphasized in higher education and in medical education as well. The delivery of medical education is quite different and complicated in comparison to any other graduate courses available in the universities.[3] Acknowledging the ultimate goal in mind, planned and implemented reforms have been predominantly targeted toward improving teaching-learning and assessment strategies in medical education, so that the intended learning objectives of the course can be effectively accomplished.[1]

Medical teachers are the strong stakeholder of the entire medical education system. Conventional role of the medical teacher as 'information provider' has undergone immense changes in recent years. Now they have to play the role as facilitator, curriculum planner, course developer, resource material creator, student assessor, mentor, program evaluator and so on. So the teachers require to update themselves and coop with the changes to meet the demand of the rapidly expanding horizon of medical education. Teacher evaluation (TE) is a series of activities and actions that are interconnected and related to a specific purpose. TE is important in the

teaching-learning process. The medical profession demands to be increasingly concerned with the evaluation of teachers' performance as a part of its accountability. Meaningful evaluation provides high quality professional development for every teacher based on country standards and identified needs of students and teachers. Teachers should be evaluated in all domains relevant to their teaching objectives; these include knowledge, clinical competence, teaching effectiveness and professional attributes. It notifies them about their duties and responsibility assigned, and traits, qualities and characteristics desired and identify potential employees for growth and prosperity in various aspects.[4]

Different findings on the topic of teaching effectiveness and different methods of evaluating teachers' performance, has been conducted in different institutions at different parts of the world, but there is no agreement on the best approaches of teachers's evaluation. So to provide an adequate and unbiased evaluation program, evidence or data can be collected from students, colleagues, and chairs, or from faculties on their own.[5] Berk proposed the sources may be students' rating, peer rating, self-evaluation, videos, student's interviews, alumni rating, employer's rating, administrator's rating, teaching scholarships, teaching awards, learning outcome measures, and teaching portfolios. Such strategy builds on the strengths of all sources, while compensating for the weaknesses in any single source, depending on various elements like contingency of situation, cultural difference, nature of the class and student differences.[6]

There is paucity of formal policy or guideline for teacher evaluation in medical education in Bangladesh. With an increasing number of medical colleges both in governments and non-government sector in Bangladesh, there is also an increasing demand of medical teachers. Without quality teachers, quality education is unattainable. Recently Director General Medical Education has started a pilot program of student evaluation of teachers in 32 governments and non-government medical colleges, receiving the result of this pilot program it will be implemented in all medical colleges.[7] Study conducted in Bangladesh regarding views of medical teachers and students on TE, its potential use and misuse and barriers, both in medical education and dental education, all have concluded that teacher evaluation is required and important,[8,9,10] but none could design a means to implement it. So the study is designed to find out the views of the teachers regarding TE, sources of information, uses, merits and demerits of different sources, challenges and suggestion to overcome challenges to implement TE in medical colleges of Bangladesh

Methodology:

This descriptive type of cross sectional study was conducted over twelve months from July 01, 2022 to June 30, 2023 in conveniently selected four governments and four non-government medical colleges, out of which four were situated within Dhaka city and four outside Dhaka city. All medical teachers of the selected medical colleges were the study population. Inclusion criteria were teachers, who were present during the period of data collection and were willing to participate in the study. Teachers who failed to return the filled-up questionnaire timely, incomplete filling or inconsistency of filling were excluded from the study. Conveniently selected 277 medical teachers of different discipline and different designation, had participated in the study. Data were collected through a self-administered semi-structured questionnaire, which was developed and finalized after pre-testing with teachers of another medical college, other than the study area. Most of the responses in the questionnaire were collected at a 5-point Likert scale, with the rating Strongly Disagree-1, Disagree-2, Neither disagree nor agree-3, Agree-4, Strongly agree-5. In addition, some of the responses were in the form of single best answer and 5 responses were in percentages regarding weightage given to the different sources of information of TE. Prior permission from the respective authority of medical colleges and informed consent from the teachers were taken and anonymity and confidentiality of obtained information were ensured. They were free to participate or not in the study. After collection of the completed questionnaire, they were thanked for their co-operation.

Data were checked and edited after collection, and then coded, processed and analyzed by computer software SPSS-25 for Windows and Microsoft Xcel. Frequency and percentage were calculated for quantitative data and mean and SD were calculated of the level of agreement on Likert's scale, and mean of agreements were further converted in to percentage out of 5, highest point in Likert's scale. All the data were presented in tables and figures as appropriate. Ethical clearance was obtained from IRB of Center for Medical Education, Mohakhali, Dhaka. Opinion received were kept confidential and anonymous.

Results:

A total of 277 medical teachers of different discipline and different designation of 4 governments and 4 non-government medical colleges of Dhaka city and outside Dhaka city were enrolled in the study. Majority of the respondent teachers were Assistant professor (45.1%, 125) followed by Associate professor (17.3%, 48) and Professor (12.6%, 35).

Thirty-seven (13.4%) were lecturer and 32 (11.6%) of the respondents were registrar. Among them 168 (61%) were male and 109 (39%) were female. Among the respondent teachers 73% (202) were from government and 27% (75) were from non-government medical colleges.
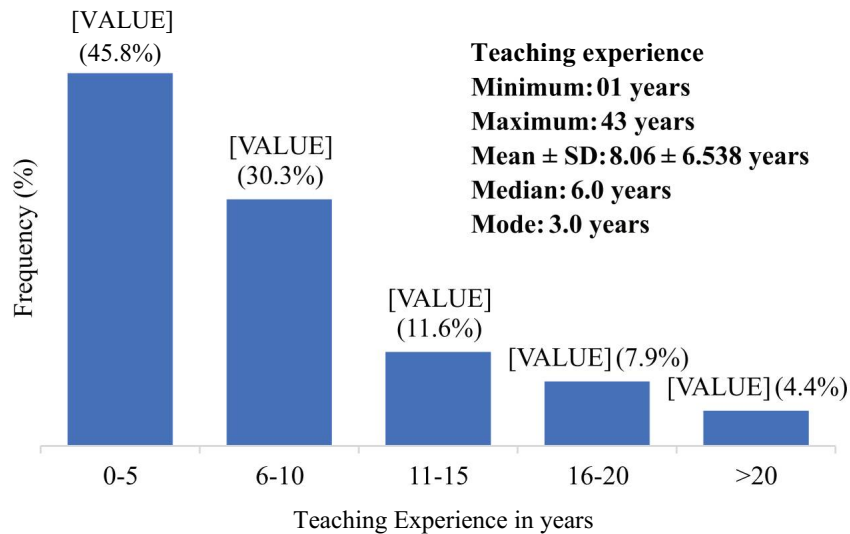

Teaching experience
Minimum: 01 years
Maximum: 43 years
Mean ± SD: 8.06 ± 6.538 years
Median: 6.0 years
Mode: 3.0 years

Figure 1: Distribution of respondent teachers' by teaching experience (n=277)

Figure-1 shows that majority (45.8%) of the respondent teachers had teaching experience ranging from 0-5 years, followed by 30.3% for 6-10 years. Only 12(4.4%) respondent had experience more than 20 years. Range was from 1 to 43 years, with a Mean ± SD=8.06±6.53 years.
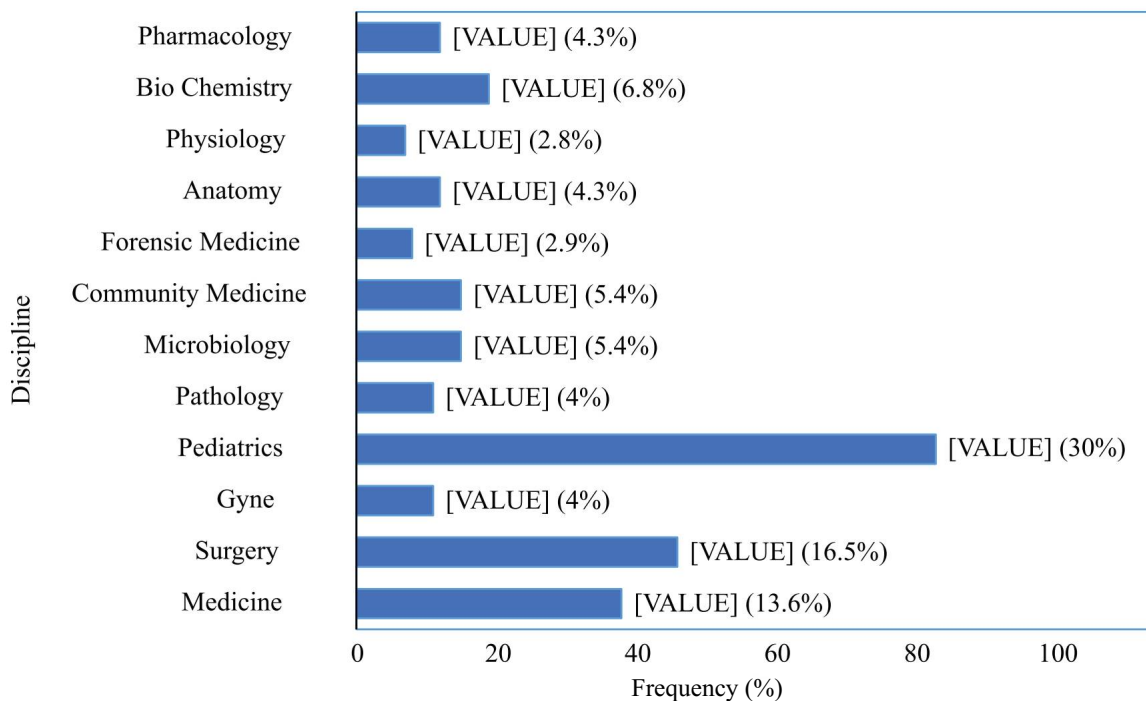

Figure 2: Distribution of respondent teachers by discipline (n=277)

Figure-2 shows, most of the respondents were from Pediatrics and its branches (30%), followed by Surgery and its branches (16.6%) and Medicine and its branches (13.7%). Among the para clinical subjects Community Medicine and Microbiology were 15(5.4%) each followed by Pathology and Forensic Medicine (4% and 2.9%). Among the basic subjects most Biochemistry (6.7%) followed by Anatomy and Pharmacology (4.3%) each and Physiology (2.8%).

Table-1: Distribution of the views of medical teachers regarding general issues related to teacher evaluation (n=277)

Issues related to teacher evaluation	Frequency (%) of 1 evel of agreement					
	SDA=1	DA=2	NDNA=3	A=4	SA=5	M ean±SD
A wel 1 - organized teacher evaluation (TE) is necessary for imp rovement of teacher performance (n=276)	7(2.5)	4(1.4)	1(0.4)	104 (37.7)	160 (58.0)	4.47±0.806
TE can maintain a standard academic environment (n=277)	7(2.5)	1(0.4)	11 (4.0)	154 (55.6)	104 (37.5)	4.25±0.772
TE shoul d be mandatory for all teachers (n=272)	7(2.6)	10 (3.7)	18 (6.6)	147 (54.0)	90 (33.1)	4.11±0.875
Evaluation results should be kept confidential (n=276)	6(2.2)	19 (6.9)	21 (7.6)	119 (43.1)	111 (40.2)	4.12±0.968
TE should be optiona 1 for those who seeks promotion (n=271)	62 (22.9)	111 (41.0)	28(10.3)	55 (20.3)	15 (5.5)	2.45±1.203

Agreement on 5-point Likert scale, with the rating SDA = Strongly Disagree, DA = Disagree,

NDNA = Neither disagree nor agree, A = Agree, and SA = Strongly agree.

Out of 5-point Likert scale the mean scores of agreement on the different issues related to general aspects of teacher evaluation (TE) were within 4.12 to 4.47 except the issue 'TE should be optional for those who seeks promotion' was 2.45 (Table-1).
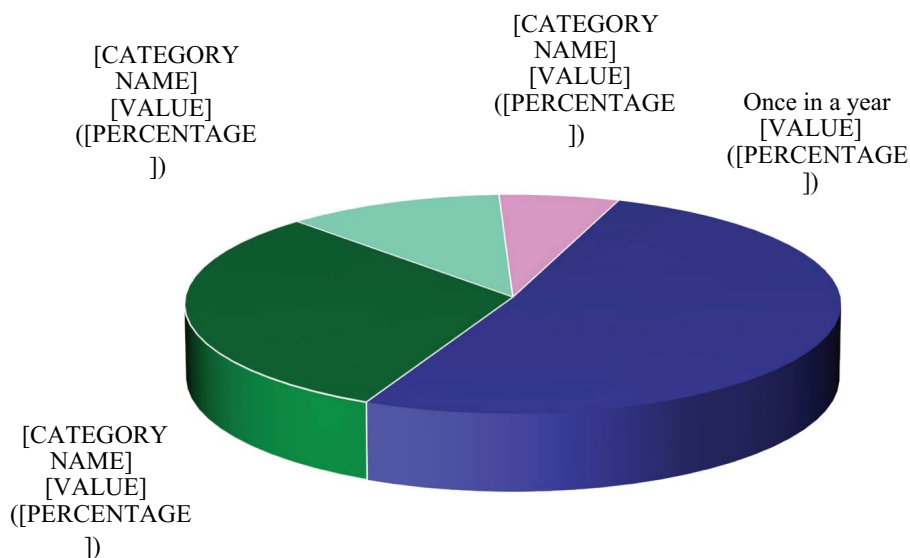

Figure 3: Distribution of teachers view on frequency of teacher evaluation in a year (n=255)

Figure-3 shows that majority (52%) teachers agree with the evaluation for once in a year, followed by (31%) for twice in a year. Only 11 % agree for three times a year and rest 6% agree for any time decided by authority.

Table-2: Sources of information for teacher evaluation with weightage given by the teachers

Sources of information for TE	Teacher Mean(±SD ¥
Rating by student	26.30 ±15.45
Rating by peer/ colleagues	14.41 ±7.74
Self -rating	18.25 ±9.69
Rating by trained evaluator	21.32 ±9.64
Rating by senior teacher (Principal/ Vice principal/ HOD)	19.66±8.67

¥ = All responses were given in percentage. Respondents can put zero 0 to 100% to any source.

Teachers' put highest weightage to students ratting (26.30%), followed by trained evaluator rating (21.32%), senior teacher rating (19.66%), self-rating (18.25%), and peer rating (14.41%).

Table-3: Distribution of the views of teachers regarding the merits of the different sources of information for teacher evaluation (n-277)

Merits of different sources of information for TE	Frequency (%) of 1 evel of agreement					Mean± SD
	SDA=1	DA=2 NDNA=3		A=4	SA=5	
Rating by students is important as they are the main stakeholders of teaching learning process (n=277)	6(2.2)	11(4.0)	19(6.9)	150(54.0)	91(32.9)	4.12± 0.860
Peer/ colleague/ senior teacher rating is important as they actually know better, what his /her colleague is doing (n=275)	4(1.5)	22(8.0)	42(15.3)	172(62.5)	35(12.7)	3.77± 0.825
Self -rating is necessary for self - development (n=273)	4(1.5)	10(3.7)	29(10.6)	162(59.3)	68(24.9)	4.03± 0.797
Rating by trained evaluators are most important as they have subject knowledge and training on evaluation (n=277)	3(1.1)	14(5.1)	11(4.0)	152(54.8)	97(35.0)	4.18± 0.813

Agreement on 5-point Likert scale, with the rating SDA = Strongly Disagree, DA = Disagree,

NDNA = Neither disagree nor agree, A = Agree, and SA = Strongly agree.

From the above table on the merits of different sources of TE perceived by teachers', from the mean agreement out of 5 point Likert scale, it is found that trained evaluator rating is most appropriate (4.18), followed by students rating (4.12), self-rating (4.03), and peer rating (3.77).

Table-4: Distribution of the views of teachers regarding the demerits of the different sources of information for teacher evaluation (n-277)

Demerits of different sources of information for TE	Frequency (%) of 1 evel of agreement					Mean ±SD
	SDA=1	DA=2	NDNA=3	A=4	SA=5	
Students fails to comment on teachers' depth of knowledge (n=277)	6(2.2)	78(28.2)	46(16.6)	132(47.5)	15(5.5)	3.32± 1.547
Students rating may be biased (n=277)	4(1.4)	53(19.2)	58(20.9)	134(48.4)	28(10.1)	3.47± 0.961
Self -rating is biased as no one sees his/her deficiency properly (n=277)	3(1.1)	51(18.4)	35(12.6)	158(57.0)	30(10.9)	3.58± 0.947
Peer/ colleague rating may be influenced by personal relation or political ideology (n=260)	1(0.4)	17(6.1)	18(6.5)	198(71.5)	43(15.5)	3.96± 0.706
Availability of trained evaluator may be less (n=260)	8(2.9)	12(4.3)	27(9.7)	188(67.9)	42(15.2)	3.88± 0.819

Agreement on 5-point Likert scale, with the rating SDA= Strongly Disagree, DA = Disagree,
NDNA = Neither disagree nor agree, A = Agree, and SA = Strongly agree.

From the above table on demerits of different sources of TE perceived by teachers', from the mean agreement out of 5 point Likert scale, it was found that the most important demerits of different sources of TE is biased peer/ colleague rating (3.96), followed by less availability of trained evaluator (3.88), biased self-rating (3.58), biased students rating (3.47), and failure of students to comment on teacher's depth of knowledge (3.32).

Table-5: Distribution of the respondent teachers regarding the challenges to be considered in teacher evaluation (n=277)

Challenges of teacher evaluation	Frequency (%) of 1 evel of agreement					Mean ±SD
	SDA=1	DA=2	NDNA=3	A=4	SA=5	
May create unhealthy competition among teachers (n=275)	16(5.8)	86(31.4)	52(19.0)	102(37.2)	18(6.6)	3.15± 1.576
May create distance between teachers and administrators (n=276)	16(5.8)	81(29.3)	56(20.3)	109(39.5)	14(5.1)	3.09± 1.058
Political commitme nt is essential (n=258)	29 (10.6)	53 (19.3)	41 (15.0)	113 (41.2)	38 (13.9)	3.28 ± 1.22 8
Extra efforts are required from the stakeholders (n=274)	3(1.1)	22 (7.9)	29 (10.5)	194 (70.0)	29(10.5)	3.81± 0.7 68
Require motivation of teachers and administrators (n=277)	0(0.0)	2(0.7)	15 (5.4)	209 (75.5)	51(18.4)	4.12± 0.505
Commitment of teachers are very important (n=260)	3(1.1)	1(0.4)	9(3.2)	162 (58.5)	102(36.8)	4.30 ± 0.653
Training is required to train the evaluators (n=260)	1(0.4)	2(0.7)	10 (3.6)	146 (52.7)	118(42.6)	4.36± 0.626

Agreement on 5-point Likert scale, with the rating SDA = Strongly Disagree, DA = Disagree,
NDNA = Neither disagree nor agree, A = Agree, and SA ,, = Strongly agree.

From the above table, challenges to be considered in teacher evaluation, from the mean agreement on 5 point Likert scale, it was found that the most important challenge is the training requirements to train the evaluator (4.36) followed by commitment of the teacher (4.30), motivation of the teacher and administrator (4.12). They also agree that requirements of extra efforts from the stake holders (3.81), political commitment (3.28), creation of unhealthy competition among the teacher (3.15) and distance creation between teacher and administrator (3.09) are other challenges of teacher evaluation.

Table-6: Distribution of the views of teachers regarding suggestions to overcome the challenges of teacher evaluation (n=277)

Suggestions to overcome challenges of teacher evaluation	Frequency (%) of 1 evel of agreement					Mean ±SD
	SDA=1	DA=2	NDNA=3	A=4	SA=5	
Legal frame work must be made earlier (n=276)	2(0.7)	7(2.5)	22 (8.0)	185 (67.0)	60(21.8)	4.07± 0.6 79
Collaboration between medical educationists and policymakers is essential (n=275)	4(1.5)	11 (4.0)	18(6.5)	175 (63.6)	67 (24.4)	4.05 ± 0.7 74
Collaboration between medical educationists and teachers is required (n=277)	2(0.7)	0(0.0)	10 (3.6)	192 (69.3)	73 (26.4)	4.21± 0.569
It should be included in Faculty Development Program (273)	1(0.4)	2(0.7)	14(5.1)	194 (71.1. 0)	62 (22.7)	4.15± 0.56 5
It should be started first as a pilot program (n=271)	0(0.0)	10(3.7)	21 (7.7)	190 (70.1)	50(18.5)	4.03 ± 0.640
DGME can introduce the standard teacher evaluation tools (n=274)	1(0.4)	2(0.7)	17 (6.2)	194 (72.8)	60(21.9)	4.13± 0 .572
Center for Medical Education should act as secretariat (n=270)	5(1.9)	6(2.2)	23 (8.5)	169 (62.6)	67 (24.8)	4.06 ± 0.766
Administrative orders and monitoring by DGME are crucial (n=271)	5(1.8)	13 (4.8)	37(13.7)	168 (62.0)	48(17.7)	3.89± 0.813

Agreement on 5-point Likert scale, with the rating SDA = Strongly Disagree, DA = Disagree,
NDNA = Neither disagree nor agree, A = Agree, and SA = Strongly agree.

Table-7 revealed the suggestions to overcome the challenges of TE, from the mean agreement on 5 point Likert scale, it was found that most importantly there should be collaboration between medical educationist and teacher (4.21), followed by TE should be included in faculty development program (4.15), introduction of a standard evaluation tool by DGME (4.13), where CME should act as secretariat (4.06). There should be a legal frame work (4.07) and collaboration between medical educationists and policymakers is essential (4.05). It should be started initially as a pilot program (4.03) and monitored by DGME (3.89).

Discussion

This descriptive type of cross sectional study, conducted from June 22 to July 23 over one year, in 4 governments and 4 non-government medical colleges with defined inclusion and exclusion criteria with the objectives of exploring the views of teachers regarding TE, sources of information for TE, merits and demerits of different sources, challenges and suggestion to overcome challenges in medical colleges of Bangladesh.

A total of 277 medical teachers of both Dhaka city and outside of Dhaka city, selected conveniently had participated in the study. Majority of the respondent teachers were Assistant professor (45.1%, 125) followed by Associate professor (17.3%, 48) and Professor (12.6%, 35), rest were lecturer and registrar of both pre-clinical, para-clinical and clinical discipline. Among them 168 (61%) were male and 109 (39%) were female. Among the respondent teachers 73% (202) were from government

and 27% (75) from non-government medical colleges. Majority (45.8%) of the respondent teachers had teaching experience ranging from 0-5 years, followed by 6-10 years (30.3%). Only 12(4.4%) respondent had experience more than 20 years. Range was from 1 to 43 years, with a mean± SD 8.06±6.53 years.

Regarding teachers' views on different issues related to general aspects of TE (Table-1), mean of agreements in 5 point Likert scale were within 4.08 to 4.47 except the issue 'TE should be optional for those seeking promotion'. Converting the mean agreement in to percentages, 89.4% teachers were in favor of a well-organized TE for improvement of teacher performance and 85% teacher agree that TE can maintain standard academic environment within the institution. Approximately 82% teachers were in favor of mandatory TE and confidentiality of evaluation results. Only 48.6% responded for an optional TE applied only during their promotion. It is obvious that the teachers of the medical colleges are already highly motivated regarding the need of a TE system for them. Again they are not in favor of an optional TE that should be applied only during promotion. Study conducted by Shahana et al. in medical colleges of Bangladesh, all teachers agreed about the necessity of TE in medical education.[8] Amin et al. found 89% dental teachers of Bangladesh were in favor of implementing TE.[9] Regarding the frequency of evaluation (Figure-3), majority (52%) teachers agree with evaluation for once in a year, followed by 31 % agreed for TE should be carried out twice in a year.

Teachers' views on sources of TE (Table-2), teachers' put highest weightage to students ratting (26.30%), followed by trained evaluators rating (21.32%), senior teacher rating (19.66%), self-rating (18.25%), and peer rating (14.41%). Bastani et al. found among faculty members of Iranian medical universities, sources of TE in order of preferences are external expert rating/trained evaluator rating (72.3%), peer rating (71.7%), mentor's advice/senior teacher rating (53.2%), self-rating (53%), student rating (17%). Highest preference was put on mixed method rating (83.3%), a combination of different sources of evaluation like students, self, peer and others.[11] Bastani et al. in another study found the multi-faceted or mixed evaluation method had the highest rank as 84.8% of the faculty members perceived this method as the best method of TE. Furthermore, in a separate comparison between the different methods, self-rating had the highest rank whereas students' learning rates and student rating were ranked second and third, respectively.[12] This difference may be due to socio cultural difference.

Regarding teachers' views on merits of different sources of TE (Table-3), from the mean agreement, it is found that trained evaluator rating is most appropriate (4.18), followed by students rating (4.12), self-rating (4.03), and peer rating (3.77). Converting the mean in to percentages, 83.6% teachers believe that trained evaluator rating are most appropriate, followed by students rating (82.4%), self-rating (80.6%), and peer rating (75.4%). Mohan in his study found majority (78%) of the teachers agreed with student evaluation while only 9.38% disagreed, the rest were not sure.[13] Shah found in their study, self-assessment by faculty themselves is equally effective to plan faculty development programs for further improvement and enhancement.[2] Almutairi & Shraid found no significant difference between teachers' self-evaluation and heads of departments' evaluation.[14] Taheri et al. compared between student rating, self rating and heads of department rating in a Medical University in Iran, found significant difference between student rating and self assessment. They concluded and suggested that student's scores of teachers' evaluation, previously used as the only one evaluation source is not enough and other sources such as assessment by the respective head of department, faculty dean and self assessment must also be taken into consideration.[15] Bastani et al. found in his study, amongst 280 faculties (83.3%) chose "mixed method rating" as the best way of evaluating and "external expert ratings" and "peer evaluation" were considered as the second and third options, respectively. He also found that 68.7% of the faculty members thought that student rating cannot be an appropriate indicative for evaluating teachers' performance lonely, because students'judgments are subjective and are not sufficiently valid.[11] Students do not have enough knowledge or experience to evaluate the multidimensionality of teaching. In addition, it has been argued that student ratings of teachers are often influenced by non-instructional factors like show man ship and gender.

Teachers' views on demerits (Table-4) of different sources of TE, from the mean agreement out of 5 point Likert scale, the most important demerit is biased peer/ colleague rating (3.96), followed by less availability of trained evaluator (3.88), biased self-rating (3.58), biased students rating (3.47), and failure of students to comment on teacher's depth of knowledge (3.32). Converting the mean to percentage, 79.2% teachers believe that biased peer/ colleague ratings are the most important demerits, followed by less availability of trained evaluator (77.6%), biased self-rating (71.6%), biased students rating (69.4%), and failure of students to comment on teacher's depth of knowledge (66.4%). Amin et al. in their study found most important demerits are prejudice, corruption,

biases in TE (100%), imposing extra cost to the institutes (100%), evaluation may not be acceptable by the implementing authority politically (97.1%), unawareness of the administrators and policy makers to perform evaluation (94.1%), requires extra time for implementing by the faculties and administrators (94.1%), requiring trained manpower (91.2%) and requiring extra manpower (88.2%). 10 Kamali et al. found, lack of trust among the faculty, fear of disclosure of results of peer or administrator evaluation, over emphasizing research work rather than educational endeavor, need for award money for high performer teachers are the potential problems.[16]

Challenges to be considered in TE (Table-5), from the mean agreement of 5 point Likert scale, the most important challenge is the training requirement to train the evaluators (4.36) followed by commitment of the teacher (4.30), motivation of the teacher and administrator (4.12). They also agree that requirements of extra efforts from the stakeholders (3.81), political commitment (3.28), creation of unhealthy competition among the teacher (3.15) and distance creation between teacher and administrator (3.09) are other challenges of TE. Converting the mean agreement in to percentages, 87.2% teacher believes that the most important challenge is the training requirement to train the evaluators followed by teachers' commitment (86%), motivation of the teacher and administrator (82.4%), requirement of extra efforts from the stakeholders (76.2%), political commitment (65.6%), creation of unhealthy competition among the teacher (63%) and distance creation between teacher and administrator (61.8%). Amin et al. found in their study, challenges are; creation of unhealthy competition among teachers (97.1%), may hamper friendly environment in the institutes (97.1%), teacher will try to satisfy the evaluator or bosses rather than concentrating on teaching (94.1%), some teachers will be rated as good who ensure easy passing of student rather than facilitate deep learning (97.1%), other opinion are unfairness may hamper implementing effective TE (88.2%), will not be cost effective (55.9 %).[10] Shahana et al. found, majority (80%) teachers think of lack of proper guideline at the policy level, involvement in national politics (75%), lack of initiative by the government (60%), lack of awareness of college authority (45%) and lack of self-interest (15%) are the most important challenges.[9] Every new initiative will have to face some challenges which will ultimately fade away with time.

Suggestions to overcome the challenges of TE (Table-6), from the mean agreement, most importantly there should be collaboration between medical educationist and

teacher (4.21), followed by teacher evaluation should be included in faculty development program (4.15), introduction of a standard evaluation tool by DGME (4.13), where CME should act as secretariat (4.06). There should be a legal framework (4.07) and collaboration between medical educationists and policymakers are essential (4.05). It should be started initially as a pilot program (4.03) and monitored by DGME (3.89). Converting the mean agreement in to percentage, 84.2% teachers believe that most importantly there should be a collaboration between medical educationist and teacher, followed by inclusion of TE in faculty development program (83%), introduction of a standard evaluation tool by DGME (82.6%), where CME should act as secretariat (81.2%). There should be a legal framework (81.4%) and collaboration between medical educationists and policymakers are essential (81%). It should be started initially as a pilot program (80.6%) monitored by DGME (77.8%). Every new effort will have to face some challenges, like medical teacher evaluation.

Conclusion:

Medical teachers are already highly motivated regarding the necessity of teacher evaluation that can be done at least once in a year. Areas for evaluation are teaching skill, class room performance, depth of knowledge, unbiased assessment, research work, publication and other parameters also. Sources may students, trained evaluator, senior teachers, self and peer. Challenges are training of the evaluator, teachers' commitment, motivation of the teacher and administrator, requirements of extra efforts, political commitment, creation of unhealthy competition among teachers and distance between teacher and administrator. Suggestions for overcoming challenges of TE are, requires collaboration between medical educationists, teachers and policymakers, TE should be included in faculty development program, introduction of a standard evaluation tool by DGME, where CME acts as secretariat, formulation of a legal framework for TE and TE should be started initially as a pilot program.

Recommendations:

1.   Medical teachers' evaluation may be started, at least once in a year.

2. Sources of teachers' evaluation may be included, in order of preferences are, students rating, trained evaluators rating, senior teachers rating, self-rating and peer rating.

3. Proper guidelines should be prepared for teachers' evaluation by the respective authority where DGME may

play key role under guidance of ME&FWD of MOHFW and in collaboration with BM&DC. Proper evaluation tool should also be developed for each type of evaluator and facilities should be ensured for proper training of the evaluator.

4. Motivation, commitment and collaboration of all the stakeholders should be ensured by seminars and workshops for TE.

5. There should be proper financial and administrative support from the government for teachers' evaluation for its successful implementation in medical education.

Limitations:

This study was performed in only few government and non-government medical colleges of Dhaka city and outside of Dhaka city, selected conveniently. Teachers were also enrolled conveniently those who were present during the time of data collection. Opinion of all the teachers could not be collected. Results of this study do not reflect the opinion of the medical teachers of the whole country as study places and sample size were limited. Time period of the study was also limited.

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