JCMCTA 2007; 18 (2): 43-46

DOCUMENTATION OF SOME CHANGES IN POLICY AND PRACTICE THAT MAY HAVE EFFECTS ON THE STANDARD AND OUTCOME OF MEDICAL EDUCATION IN BANGLADESH AFTER LIBERATION

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Executive Summary

Medical education in Bangladesh is in a dilapidated condition because of years of possibly inappropriate non evidence based changes atop the non prioritization of various essential elements that was inherited besides absence of standard target based reformation. The situation demands critical review and appropriate customized reformation that should be balancing of accepted standard norms and spirit.

Background

Modern medical education has been introduced in this land in early 20th century by the colonial British rulers with an aim just to produce some health care providers and under strict control of public service domain vis a vis military control with a service priority mode. The education and science have been ignored. After leaving of the colonial rulers the same mechanism is remained even in the liberated Bangladesh till the day.

Introduction

Medical Education is a tertiary level specialized professional education with three functional components knowledge, skill and attitude (KSA) and two dimensions, service and science. This education needs special management and dispensation. No where in the civilized world a tertiary professional education is under the control of government through civil service rules which are just appropriate for general administration dispensation, even in our country except medical education. A progressive, pragmatic and productive (PPP) medical education needs consistency, continuity and credibility (CCC).

Dimension and Outcome and Indicators

Medical Education has two universal dimensions or responsibilities, academia and science through producing safe doctors and scientists respectively, with fixed outcomes and indicators that are: for medical

Medical Education		
Responsibilities	Outcome	Indicators
1. Medical academia	Safe doctors	Satisfied patients
2. Medical science	Scientists	Credible international publications & Resource persons

academia the outcome is the safe doctor and the indicator is the satisfied patient. For medical science the outcome is medical scientist and the indicator is credible international publication and resource personal development.

Year	Policy & Implementation	Impact
1972	Auto-promotion in First Professional MBBS Exam	Credibility of MBBS was lost with many consequences
1972	Empirical increase of seats in medical colleges by about 50-75%	Teacher-student-facility ratio seriously compromised with deterioration of quality and standard. Discipline and person person skill transfer seriously effected.
1972	Cancellation of GMC UK recognition	Due to the auto-promotion that resulted in closing the doors of KSA transfer and updating in abroad specially in UK.
1972	Closing the ECFMG centers and embargo on doctors to go abroad	Closing the doors of medical graduates for participation and anchoring their places in USA and other countries plus KSA transfer and advance training.
1972	Introduction of district quota and fixing colleges for particular districts	Universal rule of merit priority has been ignored with regionalization of medical colleges with diminution of guardians' supervision on students.

Changes in Policy and Practice over the years

The changes were made over the years since liberation of Bangladesh in medical education dispensation and professional practice operation.

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1972	Introduction of Bangla as medium of instruction replacing English in HSC level	Seriously incapacitated the students who cannot even follow essential textbooks not to speak of communication and expression orally and through writing. To salvage the situation short term English course has been introduced through public spending during MBBS course reducing the period with burdening the over burdened exercises. Moreover this course is found to be inappropriate and useless.
1975	Introduction of Palli Chikitsak and Medical Assistant Program	That has converted Health Care Auxiliaries and Health Workers to doctors with unlimited scope of abusing medicines and procedures without regulatory control.
1975	Separation of college and hospital administration	This has jeopardized the continuing process of clinical teaching learning and research. It also covertly has changed the status of medical college hospital as the lab of the college from clinical education to more priority to patient service at the expanse of standard of medical education. Registrars and residents are primary level teachers being hospital controlled hence college administration cannot use them optimally for the education and training purpose. Moreover high priority to service with out control of patient admission usually overwhelms all the systems hence the clinical teaching environment has been facing difficulties to maintain. A psychological complex always in operation between the college and hospital administration. This has been augmented by upgrading the rank and status of director of the hospital.
1977	Introduction of new version of Inservice Training Scheme	This training scheme compromised the ability of a basic doctor by reducing over all exposures on all related major disciplines in favor of enhancing one. Though the nation needs basic doctor based on universal Primary Health Care declaration.
1978	Withdrawing non-practicing allowance and allowing hospital residents for private practice	Residents are by definition the whole time personnel in the hospital taking care of the patients and clinical education. They were earlier compensated by some facilities and non practicing allowance. With withdrawal of these and allowing them to practice the whole time resident coverage of hospital had been impaired. Moreover the medical education has been suffering too, because residents are primary clinical teachers in the hospital. The off-office hours clinical teaching that is by convention most effective skill learning/transferring time has been suffering.
1980	Establishment of 5 new medical colleges	Without appropriate assessment and ability new medical colleges were established that are chronically under staffed and deprived of optimum facilities leading to compromising of the quality.
1982	Change of working hours from 0900 - 1700 with 2 days of weekend holidays	This has changed the attitude of medical students and clinical teachers of attending the evening teaching learning sessions because after days works it's not possible again to attend or organize the sessions. On the other hand the two morning vital hours were not utilized. From then onwards the traditional most effective nocturnal clinical teaching learning culture has been fading.

1982	Massive transfer and retransfer of medical teachers	That led to vacuum for teachers resulting in compromising in the course conduction, supervision and assessment resulting in serious decline of standard and, since then that has been turned out to be the baseline standard.
1983	Inclusion of Student Union Representatives in Academic Council	Academic Council is the highest body of the medical college for policy forming, implementation, supervision, and ensuring of discipline. Inclusion of student union representatives has reduced the cutting edge decision taking capability of this body and in presence of students most of the times it becomes embarrassing for the teachers to discuss sensitive issues appropriately and take proper decision. This mostly in cases of attendance requirement, exam standard, politically dictated matters and many others. Because of the political linkage students union representatives used to be fear factors.
1988	Curriculum change with paradigm shift with 3 exams per professional MBBS	This changes lead to many exams for too many students resulting in scarcity of examiners which had been covered by compromising the BMDC stipulated examiner's criteria. With too many students with less quantum of period this has been declining the standard of assessment. Moreover with a fixed percentage of pass students use to take chance being aware that in any exam he or she would pass.
1989	Introduction of medical courses in private institutes	Without full filling all the basic requirements by the respective institutes and without ensuring unbiased monitoring and accountability permission was accorded which has seriously compromised the Knowledge-Skill-Attitude ie the standard of education of students of those institutes.
1990	Appointment of BMA President as Adviser of Care-Taker Government	This has lead to mold the professional organization which has historically the role of guiding, updating and regulating the members in the pursuit of profession into a profiting venture with power pivoting and, politicizing the organization and professionals.
1997	Abolishment of aptitude test through oral exam in the admission test	The essential subjective aptitude of the medical admission seekers has been seriously compromised.
2002	Introduction of postgraduate program in medical colleges	Over burdening the already over burdened institutes this program may not able to produce standard postgraduates with the available set ups and facilities. In addition the undergraduate attitude of teachers and examiners is not appropriate for postgraduate courses and assessment. Moreover there is dire scarcity of external examiners leading to compromise of the standard. In addition in the admission test no minimum score has been kept and as a result just to full fill the quota there is scope for admission even for an applicant without getting any score.
2002	Introduction of 2002 Curriculum without piloting	Highly task specified curriculum 2002 over laden with too many assessments and exams that are not conducive with the manpower, appliances, logistics, time and others, as a result teaching and assessment are compromised.

2002	Reduction of preclinical years from two to one and a half years in absence of comprehensive formal premed in higher secondary level	In 2002 curriculum preclinical period has been reduced to one and a half years from two years. This is feasible where there are very strong pre-medical courses in higher secondary level. The result is weakening of the very basic foundation of knowledge, skill and attitude. Moreover contents of preclinical courses have been increased that is not commensurate with the allocated period. This curriculum allowed students to carry over accross professional exams without passing there by seriouly undermining the standard.
2003	Introduction of New Internee Training Scheme	There are three major clinical disciplines that are a must for a basic graduate doctor to have training viz Medicine, Surgery and Gynae/Obstetrics. In this scheme keeping medicine a must one has to choose either surgery or gynae/obstetrics. A medical graduate with this training being engaged in the primary health center or general practice may never handle a labor properly which is an essential day to day health care need of the community if he chooses surgery or in other instance may not handle a primary surgical situation if he chooses gynae/obstetrics.
2005	Change of recruitment rules of medical teachers (One time relaxation)	Earlier the entry to the teaching post was the Assistant Professor but with this rule after 15 years of service one can able to be a professor without passing though the essential phases in between.
2006	Empirical increase of seats in medical colleges by about 25%	Has further deteriorated the already compromised teacher-student-facility ratio that has converted medical colleges into an unmanageable setup in all definitions.

Summary

The net result of the current state that is prevailing in the medical education sector is 'Unmanageable number of students to be dispensed with unmanageable curriculum with serious compromised facilities to produce some certificate holders'. The system has been failing to produce safe doctors and scientists. There is not a single center in the country which can command as a model one in terms of education, science and service in a holistic manner. There is no visible impact of the medical education in production of credible scientific experts and resource persons. Hence where our neighboring countries are supplying scientists and resource persons and earning foreign exchanges vis a vis making their profession scholastically self reliant, we have to depend on the import of that. Though the country is a virgin land for research and development there are scarcities of research and development ventures. Even we have very meager capacity to identify our own problems scientifically not to speak of finding the evidence based solution.

Basis of the policy and practice changes

An endeavor was attempted to find out the reasons behind these policy changes. the apparent summary is as follows:

1. Conceptual paucity: service synonymous with education and science
2. Empirical and political directives
3. Immediate gain of vested interests
4. Pressure of some concerned quarters
5. Lack of far vision
6. Aim less non thematic venture
7. Non prioritization of medical education and science vis a vis service delivery
8. Non evidence based approach
9. More emphasis on applying public service rules which is not conducive for medical education dispensing setups.

The need

Immediate evidence based situation analysis and reformation following a standard tested medical education system and operation model. We have no time for experimentation other than following any one model of the global bipolar medical education, either American or British. In this behalf All India Institute Medical Sciences or Mahidol University or Oxford University may be taken as a model.