

REFORMS IN MEDICAL EDUCATION: TRENDS & CHALLENGES

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“Twenty years ago, Journal of Chittagong Medical College Teachers' Association in its inaugural issue (Vol 1, No 1, June 1990) published an editorial ‘The Medical Education at Cross Road’ which depicted the sorry state of medical education, then prevailing under the rule of triumvirate Government, University and BM&DC (Bangladesh Medical Dental Council)’ on one hand and the determination and leadership of the teachers of Chittagong Medical College to peruse the path of progress. The editorial concluded with this note: “The crux of problem of medical education lies with proper administration of the Medical Colleges and Institutions. A very powerful group prefers statusquo the inherited colonial legacy. The enlightened section thinks that the outdated bureaucratic system has been responsible for all the backwardness of our medical education and the solution lies in the creation of the autonomous (academic, administrative and financial) medical colleges and Institutions. Till such time our medical education has to wait at the crossroad.”

Unfortunately today, twenty years later our medical education is still waiting at the crossroad for the long cherished reforms in curriculum and governance to meet the rapidly changing demands of the medical practice and to keep pace with explosion in information, new technology and innovations world over.

Key goal of medical education is to improve the quality of health care. What doctors do and how competently and caringly they do it depends on quality of education that our medical colleges and medical teachers provide to today's students to be tomorrow's doctors. In an increasingly quality conscious society, doctors have moral, social and even legal obligations to stay updated and deliver best of care to patients.

The question is whether knowledge, skill and values

that our graduates learn to-day are in right balance to be the life long self directed learners the committed physicians of 21st century.

Since early 1900, when scientific basis of medical practice has been recognised, traditional medical curriculum developed emphasising more on scientific aspect of medicine compared to skill and values. Over the last several decades increasing concerns over the short coming of traditional medical curriculum has been expressed by the medical educators. The traditional curriculum has been criticized as highly teacher centered (teachers knows best and most), lecture based (taxes memory, not the intellect and favours passive learning), discipline specific with preclinical and clinical divide (lack ability to integrate and apply 'knowledge' to solve clinical problem) and with content-based evaluations (favours memorization, recall and regurgitation).

Reappraisals of the relevance and effectiveness of the traditional curriculum have provided the necessary impetus for the significant changing trends in medical education which included-

- i. integration of inter-disciplinary curriculum aiming at horizontal and vertical integration of medical care resulting in myriad forms of integrated modular courses and several forward looking reforms within traditional curriculum,
- ii. educational strategies promoting active learning and early introduction of clinical experience resulting in introduction of problem based learning, task-based learning, integrated learning activity, community orientation of medical education and evidence based medicine,
- iii. opportunity to practice skill under the guidance of experienced teaching physicians as opposed to being passive observer,
- iv. acquiring professional values that put the needs of the patients first and
- v. learner centred self directed learning extending throughout professional life with Continuing Medical Education (CME) and Continuing Professional Development (CPD).

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Undergraduate medical education in Bangladesh though remained traditional and discipline specific, there had been atleast three very forward looking reforms namely

i. defining 'core' (must know) and 'additional' (nice to know) contents in each discipline, ii. community orientation of medical education with introduction of Residential Field Site Training (RFST) and iii. clinical orientation of basic science courses. Even after decades of its implementation, we could not harvest the benefit of these reforms principally because-

i. 'Core contents' were inappropriate as they were not based on 'competences' a graduate is expected to acquire (as a consequence course contents became lengthy, repetitive and boring)

ii. objectives of RFST were not made clear to its implementors and its operation made dependent on availability of project fund (as a consequence community orientation became a lip service)

iii. Although significant progress has been made towards clinical orientation of preclinical courses, there is still lot more works to do.

Today as we embark on review of our curriculum, we should be pragmatic to identify deficiencies objectively and seek remedies appropriately. Only changing the number of professional examinations (from 4 to 3 or vice versa) with few casual additions or deletions here and there will not serve our long term goal. The issues that should receive due considerations include:

i. Defining the course objectives and preparing a list of competences (in terms of knowledge, skill and attitude) that a doctor should acquire on graduation.

ii. Redefining the core-contents (must know) of different disciplines based on pre-determined course objectives and competences. This will greatly reduce the core-content, avoid repetitions among disciplines and make the in- and end-course evaluations more objective and easier for students.

iii. Promoting active learning and early clinical exposure (both of which have proved to be effective) by changing teaching-learning strategies. These may include-assignments for students, problem or task based learning, evidence-based medicine, community orientation etc. The objectives, scope and operative

iv. Strategies of RFST should be reformulated to make it effective and useful for the students. Didactic lectures should be discouraged.

v. Introducing pragmatic in-course and end-course evaluations based on core-content and listed competences. Several forms of MCQs (Multiple Choice Questions), MEQs (Modified Essay Questions), EMOs (Extended Matching Questions), SAQ (Short Answer Question) etc may be introduced to gradually reduce or even replace oral part of the examinations which is highly unreliable, highly subjective, at times coercive even after so-called SOE (Structured Oral Question) and in the present forms too much time consuming and therefore not feasible. If oral part cannot be do away with, its weightage can be reduced and or multiple sets of examiners (each set of 2 examining 15-20 students only) for a centre may be considered.

However, the crux of the problem of medical education today as it was 20 years ago remained the 'governance' of the medical colleges and institutes. Highly centralized control within the medical education and health care systems in the name of uniformity has led us only to a static position – sans progress, sans quality. The challenge therefore is to seek for progress, innovations and quality in diversity and that depends on creation of fully autonomous medical institutes or Universities. Will not the medical teachers take up the challenge?